MEDICARE MODERNIZATION: EXAMINING THE FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM AS A MODEL FOR SENIORS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

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WEDNESDAY, MARCH 20, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Deal, Burr, Whitfield, Ganske, Norwood, Bryant, Buyer, Brown, Waxman, Strickland, Barrett, Capps, Pallone, Wynn, and Green.

Staff present: Patrick Morrisey, majority counsel; Steve Tilton, health policy coordinator; Chuck Clapton, majority counsel; Eugenia Edwards, legislative clerk; Amy Hall, minority professional staff; Bridgett Taylor, minority professional staff; Karen Folk, minority professional staff; and Nicole Kenner, minority research assistant.

Mr. BILIRAKIS. The hearing will come to order. The Chair apologizes to the panelists, as well as to the people in the audience. Frankly, we could not get on an elevator that had room for us.

As per usual, and as per the rules, the Chair will recognize himself and the ranking member for 5 minutes, and all others for 3 minutes for an opening statement. I would like to welcome all of our distinguished witnesses.

You all provide such valuable insight as we tackle these daunting issues, and I anxiously await your testimony, but I would particularly like to welcome Steve deMontmollin and Bobby Jindal.

As many of you may know, Bobby, Mr. Jindal, was the former executive director for the Bipartisan Medicare Commission on which I served as a member.

Mr. Jindal then took his expertise to Louisiana, and is now back helping the Nation as the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

It is a pleasure to see you again and I look forward to working with you as we continue to tackle this continuing problem of modernizing Medicare.

Steve serves as the Vice President and General Counsel for AvMed, the largest not for profit health plan in Florida, and he is also a fellow Gator as I understand.

I am pleased to say that AvMed has been providing quality services to many people in my home State of Florida, and many other States since 1973. It is always a pleasure to welcome someone from my home State before the subcommittee.

Unfortunately, I understand that AvMed pulled its Medicare+Choice plan out of my Congressional district. I am hopeful that you will be able to speak in your opening statement as to why AvMed was forced into making that decision.

And I look forward to hearing about what I can do to encourage AvMed to come back to the district. I know that close to fifteen hundred Medicare beneficiaries were enrolled with AvMed, and I am sure that they would love to renew their service if you are willing return to the area.

This is very important to me. I want to make sure that if we are going to help beneficiaries maintain access to choices, then we fix the problems in such a way that at a minimum, it ensures that plans will stay in Medicare+Choice and hopefully return to the program.

Since first coming to Congress, I have pledged that I would not jeopardize the future of Medicare. The hearing today will afford us the opportunity to hear from experts in how we might design a proposal to mirror the structure of the Federal Employees Health Benefits Program, FEHBP.

As many of you know, FEHBP provides many of us with our health coverage, and works very well as a national employer offered plan. I believe that there are many lessons that we can learn from this program that could, and should, be considered as we move forward with a Medicare modernization package.

Modernizing the Medicare program and its benefit package to include prescription drugs, in an appropriate fashion, is certainly most critical. It is no great secret that the Medicare program is in dire straits. The financial health of the program is in extreme jeopardy, the benefit package is woefully inadequate, and the payment structures and systems are inefficient and inappropriate.

We must work quickly and expeditiously together to develop legislation that improves the benefit package, but also does not bankrupt the country and risk the underlying benefits in the process.

Structural reform of Medicare is central to the broader debate of protecting and strengthening the program for the future. Many experts agree that if Medicare was being designed today, the two-part system that drives this payment policy would probably not be adopted.

At the same time, it may be difficult for us to dramatically alter this program in the short term. However, it is crucial that our legislation be designed to move us closer to a more modernized Medicare program.

So I would like to think that we are all committed to protecting the long term solvency of the Medicare program, and we all look forward to a productive hearing today, which will shed light on some of the fundamental issues in this debate.

The financial viability of this crucial program and the cost sharing liability of Medicare beneficiaries are some of the key issues that we must address as we move forward. This subcommittee has

a strong record of working on a bipartisan basis, and we must continue to work together to find a bipartisan solution.

This hearing will help bring us closer to accomplishing that goal as we evaluate the challenging issues inherent in any Medicare reform proposal. So again, in closing, I want to thank our witnesses for their time and effort in joining us, and I now recognize the ranking member, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. I just want to thank Marilyn Moon for joining us and for Max Richtman for joining us also. I appreciate the chairman's sincerity, and I know from working with him closely over the years that his personal interest in the welfare of Medicare beneficiaries.

But I am concerned that our first hearing on Medicare reform focuses on privatizing this program that has served Americans well for 36 plus years. Our first responsibility is to add a prescription drug benefit to Medicare.

It is not right to condition our willingness to complete the Medicare benefits package on seniors' willingness to give up reliable, stable health benefits delivered through Medicare.

The administration has made it clear that it feels differently. Let's face it. The big winner in Medicare privatization, or the big winners, are Medicare HMOs and not Medicare beneficiaries.

The President's budget neglects the resource needs of every Medicare provider, and just listen to people at home, the resource needs of every Medicare provider except +Choice plans.

The administration says that this is because for some seniors Medicare+Choice is a means of accessing supplemental benefits like drug coverage. What about the other 84 percent of seniors?

Why most seniors accept private coverage to receive appropriate health benefits. I am interested in hearing what our five witnesses have to say about privatization of Medicare.

But I won't be a party to the notion that privatization of prescription drug coverage must be linked, or to the inference that the financial stability of HMOs is more important than the stability of 38 million Medicare beneficiaries.

The idea of turning Medicare into a voucher program has been kicking around Congress for several years. I understand why proponents of this approach would want to couch the issue as a choice between Medicare and FEHBP as if the voucher approach means giving seniors the added benefits available under that program, namely prescription drug coverage, lower cost sharing, with no strings attached.

It is far more politically palatable than coming out and saying the Federal Government is considering whether to transform Medicare from a defined benefit program into a defined contribution program, and people know what that means.

President Bush has certainly embraced the FEHBP rhetoric. He says that he wants to give seniors better options, like those available in FEHBP. The President has also said that he wants to help seniors pay for prescription drugs if they agree to enroll in an HMO and purchase stand alone prescription drug coverage.

The President for sure has every right to push his privatization agenda, but not by co-oping on an issue as emotional and important as prescription drug coverage. The President should not go un-

challenged when he mischaracterizes Medicare as a failed program so that he can justify his goal of privatizing it.

Whether it is Medicare privatization or social security privatization, it is disingenuous of this administration to portray privatization as in some way better for the people who depend on these programs.

The retirement safety net was not put in place because liberals wanted to make the Federal Government bigger. It should not be dismantled because conservatives want to make the Federal Government smaller.

The safety net was put in place because the private sector simply could not make a profit offering health insurance to seniors, and so they did not do it. And it was put in place because the Nation believes that Americans who helped build this Nation's unrivaled prosperity through their working years should not face financial uncertainty and hardship when they retire.

Pooling our resources into public programs was and is the best way to provide consistent, equitable, reliable income and health care benefits to our seniors. The stock market and the HMO industry may be good at many things, but alleviating uncertainty is not one of them.

And now the future of Medicare is on the line, and the President says that seniors deserve better options than Medicare, and that's why he favors privatization. A private plan superior to Medicare, would seniors be better off with a voucher that helps pay for coverage on an HMO?

Medicare is more reliable than private health plans. Medicare offers more choice, and offers more choice in spite of the word choice being thrown around at every opportunity. Medicare offers more choice than private health plans and operates more efficiently than private health plans.

It is more popular than private health plans according to a survey conducted by the nonpartisan Commonwealth Fund and Medicare far outranks private insurance as a trusted source of health coverage.

But the administration insists that it wants to give seniors more choice and better options than Medicare. Is it better to have your choice of HMOs than to have coverage that you can count on every day, every week, every month, every year?

The Medicare program covers medically necessary care and services and that beneficiaries can see the health care professional they choose, and go to the health facility they choose.

Those are the choices that matter in health care. It is a single plan and it treats all beneficiaries equally and provides maximum choice and access for patients and doctors. Contrast that with Medicare vouchers.

Instead of being guaranteed access to needed health care services, seniors would be guaranteed access to a partial voucher for private health insurance. Proponents say that this program creates choice by enabling seniors to choose the health plan that best meets their needs.

But what exactly would distinguish one plan from another? Realistically, the key differences would have to relate to the generosity and restrictiveness of the benefits, and whether you can see a doc-

tor that you can trust, whichever one is assigned to you, or whether you can get the medicine your doctor prescribes, or the cheapest one on the formulary list.

It appears that choice is actually a code for wealth. Higher income seniors can afford to supplement the voucher and buy a decent plan. Lower income enrollees would be relegated to restrictive alternatives. Some choice.

Again, Medicare is a single plan, Mr. Chairman, that treats all beneficiaries equally, provides maximum choice and access for patients.

Mr. BILIRAKIS. Please finish up.

Mr. BROWN. I will do that, Mr. Chairman. I apologize. If the administration truly wanted to give seniors something better, there would be sufficient dollars, $700 billion or so, in the budget to add a meaningful prescription drug benefit to Medicare.

Instead, we get a tax cut with benefits overwhelmingly to the most privileged in our society, with only a few dollars left for prescription drugs for our constituents.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Deal for an opening statement.

Mr. DEAL. Mr. Chairman, I will pass.

Mr. BILIRAKIS. Mr. Burr for an opening statement.

Mr. BURR. Thank you, Mr. Chairman. I would be happy to yield to Mr. Norwood if he would like it.

Mr. NORWOOD. No, go ahead.

Mr. BURR. Mr. Chairman, I will be very brief. I think Mr. Brown did an excellent job of summarizing where we have been and how we got there. Let me take this opportunity to welcome all of our panelists today, and suggest that a lot of time a lot of bipartisan effort has gone into understanding that there is a need to change some things in Medicare.

It is time to have a debate on what the scope of coverage should be, and should that include prescription drugs. Should we offer different choices to seniors on how they access their care. Can we offer a more quality way to provide that care.

To take anything off the table is to suggest that they are satisfied with what they get today. In many cases that is not the case. We have got a lot of things in health care that are broken, and the time to modernize Medicare is now.

Every year that we wait and we make it a partisan issue, we lose options. We lose options that affect the quality of care and affect the costs to the taxpayers.

Now, my hope this year is that we can pass a prescription drug bill into law, and not just through the house, and see it die by Senate leadership, choosing to use it as a political issue in the November elections, versus as a policy issue for the seniors that deserve it.

I am not sure that we can accomplish that. But if we can, we should take every opportunity to put Medicare reforms where they are appropriate, and where we can find agreement, and where they save us money, and where they increase the quality of care for seniors.

We should take that opportunity to do it now, and at the end of the day, we are responsible to make sure that the program that is

provided under this insurance—and I call it an insurance-based product because people pay into it.

They pay their entire lives to make sure that this coverage is provided for them, and the only way we fail is if we don't structure it in a way that it provides the greatest benefit for the money that is available. I again want to thank our witnesses, and I yield back.

Mr. BILIRAKIS. Mr. Waxman, you are recognized for 5 minutes.

Mr. WAXMAN. Thank you very much, Mr. Chairman, and I am pleased to welcome the panelists today to talk to us about this issue which I gather is titled, "Looking at the Federal Employees Health Benefit Plan," and seeing whether that is a good model for Medicare.

Well, I have to tell you that I think that the FEHBP is a good model in one particular respect, and that is that prescription drugs are covered under the employee plans that we have available to us, but prescription drugs are not now available to Medicare beneficiaries.

If we decide, as I think the overwhelming consensus of the American people, and of all the politicians that ran for office in this last election, if we decide to follow that consensus and cover prescription drugs under Medicare, and make it as generous as the employee benefit plan, we are looking at an expenditure of $750 billion over the next 10 years.

I think we ought to commit ourselves to passing a meaningful prescription drug benefit plan as part of Medicare. It ought to be a service the way doctor bills, hospital bills, and other medical services are now covered under Medicare.

And we ought to recognize that it is going to cost money to do it. As to the rest of the Federal health benefit plans being a model, well, I don't think the people under Medicare are unhappy with Medicare.

In fact, most of them like the way that the Medicare program works. It has been a Godsend to them that they are not wiped out by high medical bills. I don't think they are looking for more choices and a wider array of plans that will be very hard for them to comprehend whether they want to take on more costs to themselves, and less benefits, and looking at alternatives that might vary the premium from one part of the country to another.

As Sherrod Brown indicated, what people on Medicare want is a choice of doctors, and choice of medical professionals, and not hopefully to rely on a fixed panel to provide their benefits to them.

We ought to recognize something else about FEHBP. These plans frequently limit providers and they don't exceed any more than Medicare in containing costs. If we are going to reduce Federal expenditures by shifting costs to the beneficiaries, this is not a reasonable solution.

And if we are going to cover eventually nearly twice as many people, it only stands to reason that we are going to need to make a very significant increase in our commitment of resources to the Medicare program. We owe our seniors no less, and I yield back the balance of my time.

[The prepared statement of Hon. Henry A. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, once again we find ourselves at a hearing discussing how to make fundamental changes in the Medicare program. I find a certain irony in this since Medicare has long been, and remains, one of the most popular and widely supported of our public programs, ranking with Social Security.

And this is no accident, for this Mediare has been a crucial support for seniors and disabled people in this country. It is indeed, vital to their economic security and their peace of mind, to know that their health care expenses will be covered.

Of course, Medicare isn't perfect. It has one glaring deficiency that is at the top of seniors' list of what needs to be "modernized" in the program: it needs a good, affordable, comprehensive prescription drug benefit. It is that change that we owe it to all our Medicare beneficiaries to immediately pursue.

Today we are looking specifically at the Federal Employees' Health Benefits Program (FEHBP) as a model for changes in Medicare. Again, as I look at that program, I see an obvious model for what we need to do in Medicare: add prescription drug coverage.

And let's be clear: that is not adding coverage on the cheap.

All estimates are that to add to Medicare prescription drug coverage equivalent to what Federal employees and members of Congress have, will take a commitment of somewhere in the neighborhood of $750 billion over the next ten years.

I firmly believe this is a commitment we should make, and we should do it now. Waiting isn't going to make it any easier or any cheaper.

Once we adopt that improvement, we will have responded to the "reform" in Medicare that the beneficiaries want.

But there are other things they want, and one of them is that we do not undermine the current strengths of the program.

Beneficiaries want to maintain their choice of provider, they like having a defined benefit plan so that they know what benefits are covered, they like to know that their premium will be the same no matter where in this nation they live.

The rhetoric that we will hear today about what the FEHBP program can offer is choice: why shouldn't seniors have the choices that Federal employees have, we are asked.

Well, the choice people want is not to face a bewildering array of plans, all with different benefits, participating providers, cost sharing and coverage. They want to be unrestricted in their choice of their doctor. They want to be able to go to the hospital their doctor recommends. And yes, they want the drugs their doctor prescribes.

FEHBP plans frequently limit providers. To go to the doctor of your choice, you have to pay more out of pocket. I don't believe this is a choice our Medicare beneficiaries are calling out for.

Finally, of course we all know that we have to deal with the issue of the baby boomer generation going on Medicare. It means that Medicare will have to cover many millions more seniors.

But when we deal with that problem, let's remember a few things:

—FEHBP has been no more successful at containing costs than Medicare has;
—reducing Federal expenditures by shifting costs to the beneficiaries is not a reasonable solution; and
—if we are going to cover eventually nearly twice as many people, it only stands to reason that we are going to need to make a very significant increase in our commitment of resources to the Medicare program.

We owe no less to our seniors.

Thank you.

Mr. NORWOOD [presiding]. Thank you, Mr. Waxman, and I now recognize myself for 15 minutes. Just kidding. This is a very appropriate hearing for us to be holding today, and I look forward to the witnesses testimony and thank all of them for being here.

Hearings are a time in which members can learn and study, and try to make some decisions, and we are certainly at a time in the life of Medicare that we need to be learning, and listening, and thinking out of the box.

I am deeply concerned about the future of Medicare.

I believe we are approaching a point with Medicare where a senior's access to care, and indeed even the quality of care, is in jeopardy.

And perhaps it is because of the way that Medicare is structured, and perhaps there is another better way to structure it. Certainly the Medicare model makes sense or made sense when it was created 37 years ago.

It was a fee for service model, and a patient sees a doctor, and the doctor sends Medicare a bill, and the Medicare pays the doctor, and that is how the coverage worked 37 years ago.

But I think we are learning all too well that is a very expensive model that consistently leads us to difficult choices.

When we need to balance a budget, we have to either increase payroll taxes, or increase the premiums paid by seniors, or reduce the services, or reduce payments to providers.

Lately, it seems that reducing payment to providers seems to be our only answer. It is the problem that we face today, and it is only going to get worse in my opinion in the future.

I am not convinced that Medicare can be sustained if we don't look at new ways to provide seniors health care coverage other than the original model, and I think we are obligated to think about that, and look, and study other ways.

Mr. Chairman, ever since the Medicare Commission report several years ago, we have been examining FEHBP as a model for Medicare, and I think it is a very appropriate model for at least for us to consider, and seniors think that, too, at least in my district.

Providing seniors with a range of choices and allowing private coverage to compete can provide improved coverage for seniors, and I am also very interested in learning more about what this type of structure could do for Medicare's long term financial solvency.

It is important for us to consider alternatives as we examine the future of Medicaid, and not have our mind made up before we even consider it. As we have seen with physician payments, it is becoming more and more difficult for us to sustain Medicare's 37 year model without affecting access or services.

I hope that se can engage in a serious conversation about modernizing Medicare. It is not in the interest of seniors for us to bury our heads in the sand and to act as though everything is just fine with Medicare. It is not, and it is not getting any better.

I do again thank the witnesses for joining us today, and look very forward to hearing their testimony, and I would yield back the balance of my time.

Mr. Pallone, you are now recognized.

Mr. PALLONE. Thank you, Mr. Chairman. I just wanted to—I am obviously in favor of modernizing Medicare as well, but what I am concerned about here is that I think what the Republicans are talking about today when they mentioned the Federal Employees Health Benefits Program as a model is that they are trying to squeeze more money if you will out of Medicare.

And the problem is that we have to shore up Medicare. We can't keep taking away, and we need to shore up and not take away from Medicare for other health-related health care expenses.

When we talk about modernization, the biggest issue as has been mentioned by my Democratic colleagues is to provide a prescription drug benefit, and in order to do that, we need to spend more money.

I mean, if we want to have a decent prescription drug benefit, we will probably need as was mentioned by Sherrod about $750 billion over a 10 year period. And my main concern is that what the Republicans want to do in the name of reform or change in Medicare is to move to a voucher system, and that this is all budget driven.

The Federal Government would in effect provide a set amount or voucher toward Medicare, and in effect to save money. Seniors would then take the voucher and try to find a plan to cover them, and seniors who want traditional fee for service Medicare would have to pay more out of pocket.

And the poorer ones would end up choosing a cheaper option, like an HMO. And the effect I think it to kill traditional Medicare for most seniors and force them into an HMO that provides less and less coverage.

And as the budget continues to have budgetary problems because we are spending money elsewhere, what the Republicans would do is to freeze the voucher amount to save money, and seniors would get less benefits and poor quality care, and what they are doing here again is to kill the traditional Medicare.

There would no longer be any guaranteed benefit package, and the benefits would vary from region to region, and based on your ability to pay. And it would undermine the idea of Medicare being a social insurance program for anyone.

In addition the Republicans are essentially privatizing Medicare. Their private health plans that have abandoned hundreds of thousands of seniors, like Medicare+Choice plans, and in the last 2 years over 100 plans dropped out of Medicare+Choice altogether.

And an additional greater than a hundred plans reduced their service areas, and many other plans increased premiums and reduced benefits. Why should we assume that this privatization is going to help in any way in trying to make Medicare better.

Compared to private health insurance plans, Medicare has done a much better job of controlling per person health care costs, and therefore there is no reason to turn Medicare over to the private sector.

That has been shown over the last 30 years that per person private health insurance costs have increased faster than Medicare. Therefore, for protecting Medicare solvency, that should not depend on private health plans.

And, last, Mr. Chairman, the Federal Employees Health Benefit Program as a model for restructuring Medicare doesn't work, because the FEHBP system has not moderated costs better than Medicare.

It serves a much smaller population that is younger, healthier, wealthier, and more attracted to private insurance. And most importantly, the number of HMOs offering health coverage to Federal employees and retirees declined by almost half between 1996 and now.

I am not trying to be cynical, but I really believe that the Republican effort here is to save money and to privatize, and in the long run it is going to mean less access and less quality care for seniors. Thank you, Mr. Chairman.

Mr. NORWOOD. Thank you, Mr. Pallone.

Mr. Buyer, you are recognized for 3 minutes.

Mr. BUYER. I want to thank the witnesses for coming. I suppose if the accusation is that the Republicans want to bring efficiency to a system, and bring business plans and practices to government, guilty.

I think that is a good idea, and if I come from a dimension that the government is best, and if I have a social mind and think that government can always deliver things for people and be the big brother, then I suppose that the private sector really is a bad idea.

I can assure the panel of this. Myself and my comrades didn't leave freedom in their footsteps so that the liberals in Congress could turn me into a socialist later days of my life.

That is a very strong comment, but it is a song that I have heard for 10 years here in Washington, DC, that Republicans are going to cut Medicare and let it whither on the vine, or jump into "Mediscare" or something else about Social Security.

You can always tell when it is an election year in Washington, DC, because the same song and rhetoric comes out. And I can share this with the panel. I have worked in the VA system for 10 years, and I have worked with the Military Health Delivery System.

And you know what? It is a good thing when you look for efficiencies in a system, and to look at the private sector to see what are you doing that's right, and what are you doing that's wrong.

Let's do an examination of our own systems here and what we can do to improve, and when we put together with the Senate the Tricare for Life—we looked at the FEHBP, and there were some here in Congress that were saying that is what we should do with the military over 65 retiree.

I think it was wise and it was prudent for us to examine other health systems, and Mr. Pallone is correct when he said that the difficult challenge that we have here is about the patient.

FEHBP or the military health systems, it is a different kind of patient load, and we recognize that but we also have to recognize when Democrats use the word modernization, and Republicans use the word modernization, it means two completely different things.

Or if the Republicans use the word incremental improvements to health care, and Democrats use the word incremental improvements to health care, it means two completely different things.

They want incremental improvements to health care to move us to a universal health system, and we want improvements to health that improves upon the quasi-private health system that we have in our country.

And I think it is a good thing that we are going to elicit from you today, and good us ideas on how we can improve Medicare. One thing is true about this so-called modernization of Medicare, is that I am going to agree with the Acting Chairman here for a moment.

We have a tremendous opportunity, and if we don't make structural changes to Medicare—and you don't improve Medicare by just saying that we are going to add an out-patient prescription drug cost.

If we don't make structural changes to improve Medicare, we are going to be in deep trouble with regard to the budget. It is 12 percent of the budget today, and baby boomers only getting older.

And if we just want to shove this thing off to a later day, then shame on us and Congress today, because all of us will have abrogated our responsibility to the American people. I yield back.

Mr. NORWOOD. Mr. Buyer, the chairman noted that you agreed for the moment, and I am grateful for that.

Mrs. Capps, you are now recognized for 3 minutes.

Ms. CAPPS. Thank you, Mr. Chairman. As was just noted, this committee is going to be charged with an awesome responsibility this year of deciding the direction of Medicare for the next 50 years.

We will have many critical choices to make, and as we do, I want to make sure that the goal of a prescription drug benefit that seniors can count on is our first priority, in terms of Medicare, and other agendas of the program are relegated to a lesser status, and especially if they obscure this goal.

But I hope that we will also find innovative ways to extend the life and efficacy of Medicare. For 78 million baby boomers approaching retirement age, long term solvency is also a part of the issue.

Seniors have been promised that Medicare will be there for them, and tomorrow's seniors as well, and we cannot make mistakes now that could jeopardize that. Today's hearing will allow us to examine how the FEHBP model could strengthen or weaken the current Medicare system.

Many have proposed moving toward a premium support system based on this Federal health plan. It is an interesting proposal and I am glad that we can consider it today. But I am concerned about its reliance on private insurance plans and the impact that it could have on seniors' expenses.

Medicare has experimented with private health plans to improve coverage already, and most recently, and this has been mentioned already, in the Medicare+Choice Program. We have contracted with HMOs to provide expanded care to our seniors, but these experiments have produced mixed results.

Initially, many seniors were given the promised benefits, especially for prescription drug coverage. But the HMOs have found it difficult to sustain their businesses. Seniors are a high risk pool for insured, and the resources that Medicare has been able to apply have not met the request of the HMOs.

This is happening in my district. They have cut—HMOs have cut their benefits, and increased their cost sharing, and actually pulled out of areas entirely. Many of my constituents simply have no private provider option available to them.

HMOs and insurance companies are businesses. They need to maintain a profit margin. But insurance for the Medicare population is not kind to these profit margins. Insurance businesses

often can only sustain themselves by reducing benefits, or increasing the amount a senior has to pay.

If we share Medicare toward the FEHBP model, we have to be sure that seniors will not see how premiums, co-payments, and deductibles for fewer benefits. We have to remember that seniors are on a fixed income, and cannot the cost sharing that a Federal employee can.

So I am very interested in listening to our witnesses today. Thank you for being here, and I look forward to working with you, Mr. Chairman, to see that our seniors get the best health care possible. Thank you, and I yield back the balance of my time.

Mr. NORWOOD. Thank you very much, Ms. Capps.

Dr. Ganske, you are now recognized.

Mr. GANSKE. Thank you, Mr. Chairman. I think the main reason that Medicare HMOs have enrollees is that they offer a prescription drug benefit.

I also want to thank the panel for being here today. Mr. Butler, I know that you have talked a lot about medical savings accounts, of which I have been a strong proponent.

I would love nothing more than to expand this program and then add a proviso that you could roll that over tax free into a long term care plan. I think that would be really important.

I also think we can learn a lot from FEHBP. It has worked pretty well for Federal employees, and there are some lessons we will hear about today.

Yet, I represent a large rural State, a State filled with small towns, and I have a responsibility to represent my State, as well as the Nation, and I will tell you that we have few if any Medicare+Choice plans available in Iowa, because we have a significant problem with what is called the average annual per capita cost. This is a problem that I have worked on.

We have had some contention on this because there is such a large gap between certain States with low payment levels, and those with higher payments in urban areas and the Medicare+Choice plans offer prescription drug benefits that we do not have available in Iowa.

Right now, as was pointed out on the front page of the New York Times this Sunday, and which I warned about recently at a hearing, they are facing I think an impending crisis on access to care because of low payments in the fee-for-service area related to hospital and physician payments in States like Iowa, where I am told physicians simply cannot take any more new Medicare patients into their practices.

So we have to fix that, and I think we have to recognize that we have an increasingly elderly population that will require health care and there will be associated costs. So, Mr. Chairman, I am gratified and happy that we are having this hearing today.

Finally, I would just say this. I do not want to see us end up with a system where all of our eggs are in one basket. I think there is some benefit for risk reduction, in terms of diversification.

Our committee is holding a lot of hearings on Enron. A lot of people lost most of their life savings or their pensions because they had all of their investment eggs in one basket.

There is a certain benefit to having some diversity in our medical health care delivery system, because I think we can learn from different approaches. So with that, Mr. Chairman, I will yield back.

Mr. NORWOOD. Thank you, Dr. Ganske.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. ROBERT L. EHRLICH, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman, thank you for holding this important hearing on the Federal Employees Health Benefit Program (FEHBP) and the lessons we may learn from it to improve Medicare.

As members of Congress and members of this Subcommittee, in particular, each of us is faced daily with potential improvements to the Medicare system. There are a myriad of bills before the 107th Congress to improve Medicare for our nation's 40 million seniors. For instance, I am a cosponsor of legislation to allow Medicare to cover: Lab Diagnostic Tests (H.R. 1798), Breast Cancer Procedures (H.R. 536), Self-injected Biologicals (H.R. 1089), enhanced Breast Cancer Screening (H.R. 1328), Oral Anticancer Drugs (H.R. 1624), greater coverage for End-Stage Renal Disease (H.R. 2220), and increased coverage for Mental Health services (H.R. 599).

Mr. Chairman, these handful of improvements are just a small sample of the bills currently before Congress designed to keep Medicare updated with cutting-edge modern medicine to provide high quality care for our nation's seniors. We all recognize that Medicare needs constant attention and improvement. Accordingly, we now have an approach in Congress to try to improve it piece-meal, bill by bill, making a political battle out of each new health service Medicare could or should provide to our seniors. Moving to a more competitive, private model like FEHBP may deliver more services at better costs to the government and seniors.

I am pleased that we have this opportunity to discuss how the Federal Employee Health Benefits Program (FEHBP) works. FEHBP is employer-sponsored health care coverage that offers employees a wide range of fee-for-service, point of service, and managed care products. While beneficiaries have a host of plans from which to choose, the federal government pays up to 75% of a total plan's premium.

Our colleagues in the Senate, Senators John Breaux (D-LA) and Senator Bill Frist (R-TN) have introduced legislation to encourage more competition within Medicare to improve services. Legislation commonly referred to as "Breaux-Frist I" would allow the government plan to be competitive with private plans to contain costs and expand benefits for seniors. "Breaux-Frist II" encourages competition among private plans only. Seniors would have the ability to choose between private plans or the government plan.

Mr. Chairman, as we explore these difficult issues to reform Medicare, I appreciate this forum to learn more about the FEHBP, our experience with Medicare+Choice, and lessons we have learned from them both to improve the health care seniors deserve.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Mr. Chairman for holding this very important hearing. Before I begin, however, I want to recognize my good friend from the State of Louisiana—one of our witnesses here today—Bobby Jindal. Bobby, as many of you know, is the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services under Secretary Tommy Thompson. Possessing a wealth of experience on Medicare and Medicaid issues, he has really been a friend to this Committee. There are few people more qualified to testify about Medicare Modernization than Bobby Jindal.

Today, we are once again looking at ways that we can improve the existing Medicare Program and place it on a sound financial footing. Sad to say, but Medicare is going broke. And unless we come to terms with this fact quickly, we will not be able to uphold our promise to the next generation of seniors.

I would like to mention a couple of numbers that may startle you. And hopefully, convince everyone in this room that they need to join the fight and get serious about modernizing Medicare. This may be one of the single most important issues Congress votes on this year.

Currently, Medicare, Medicaid and Social Security comprise about 55 percent of the total federal budget—55 percent. By the year 2012—and that's not that far away—the total of these entitlement programs will rise to 69 percent of the federal budget. And if we fast forward to the year 2030—entitlement spending will grow to over 80 percent of the federal budget. That's over 80 percent. 30 percent of the budget alone will be spent on Medicare and that's before you even factor a prescription drug bill into the mix.

Obviously, we can't sustain this level of spending. With an estimated 77 million people expected to be enrolled in Medicare by 2030, it's pretty clear we are rapidly moving toward a financial crisis, unless we take some pretty dramatic steps.

So what are those steps? What type of reforms can we act on to ensure that Medicare will be around for our children?

One of the reforms that has been suggested by quite a few smart people, including our friend Bobby Jindal, when he was the Executive Director of the Bipartisan Medicare Commission, is moving to an FEHBP model of delivering health care benefits to seniors. This reform, if implemented properly, has the potential to save a modest amount of money over time, but also provide beneficiaries with a wide range of benefit choices, including managed care options, point of service options and fee-for-service.

Members of Congress have excellent health care benefits and participate in a system that improves automatically over time. Why shouldn't our Nation's seniors? Why should our seniors have to wait for an act of Congress before adding an innovative new benefit to the Medicare Program? Under an FEHBP model, seniors wouldn't have to.

I'm not going to tell you today that FEHBP is perfect and that we should replicate every part of that Program. But FEHBP works. And there are many lessons we can learn from it. For example, FEHBP reimburses a plan after it submits a bid and negotiates a contract with the Office of Personnel Management (OPM). Why can't Medicare function the same way? Shouldn't Medicare plans be required to assume some of the financial risk of providing health care to seniors? FEHBP plans do.

Under FEHBP, plans compete against each other and have financial incentives to offer high-quality, low-cost products for enrollees. Why can't Medicare operate in this manner? Also, isn't it about time that government plans compete against private plans on a level playing field? Why should the government plan receive an unfair advantage and receive higher federal subsidies than a private plan? We have seen the disastrous results of that policy in today's Medicare+Choice system where private plans are often receiving 2 percent annual payment increases compared to fee-for-service increases of 5.5%. Private plans end up being under reimbursed in such a system and the health care marketplace becomes distorted. Is it any wonder that private plans will withdraw from a market if you underpay them vis-à-vis fee-for-service?

Obviously, there are many different ways that we can replicate the FEHBP system. Senators Frist and Breaux have introduced two different pieces of legislation with varying levels of competition. We should look at both of those bills and examine whether the ideas behind Breaux/Frist I or Breaux/Frist II should be incorporated into the Medicare legislation we move through this Committee. Senators Breaux and Frist have done a great deal of work on this issue. It would behoove our Subcommittee to build upon that work and produce a product that can help turn the direction of the Medicare Program around.

Lets face it. We can't afford to sit still this session of Congress and let another year go by without making structural reforms to the Program. Today, we only focused on one of them. Of course, we also need to add a prescription drug benefit to the Program, modernize the existing benefit package, develop a more comprehensive measure of Medicare's solvency and bring many other needed changes to the Program. The list of needed reforms is long and certainly not without controversy.

But our parents, our children, and all Americans are counting on us to strengthen Medicare this year. We should not let them down.

Mr. Chairman, you are exploring an incredibly important subject today. This is not a brand new issue, but its significance cannot be understated. We have high-caliber witnesses appearing before us today. I hope they can provide us with some guidance regarding how we can make an FEHBP model work for Medicare.

Thank you.

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you Mr. Chairman for holding this hearing today.

The Medicare program is one of the most important social health care programs in our country's history.

Before Medicare was created in 1965, nearly half of seniors had no health insurance, and one third were living in poverty.

Today, 97 percent of all seniors have health insurance, and the number of seniors living in poverty has been cut by 60 percent.

This program is a guarantee that all seniors—who have worked their whole lives to make this country great—have the health care they need in their golden years.

Whatever changes Congress makes to this program, we must make sure that we do not undermine that basic principal of the Medicare system.

Unfortunately, some proposals—namely the ones modeled after the FEHBP—would shift health care costs from the federal government to seniors.

There are several problems with modeling the Medicare system after the FEHBP.

First of all, comparing Medicare beneficiaries to FEHBP enrollees is like comparing apples to oranges.

Medicare beneficiaries are considerably older than FEHBP enrollees. As such, Medicare beneficiaries have medical needs that are vastly different from individuals in the FEHBP.

The average 75 year-old person has three chronic medical conditions and regularly uses about five prescription drugs, as well as many over-the-counter remedies. In many cases, older people are using 12 prescriptions or more at any given time.

More than one in four people at age 75 report at least one disabling condition. By the age of 80, three out of four people report a disabling condition.

Age related social and psychological factors, such as retirement, widowhood, bereavement and isolation can compound the health care challenges for seniors.

The reality is that our elderly population is expensive to care for.

This is true for seniors across the country.

But if we moved to an FEHBP model, seniors would have different benefits and different costs based on where they live.

Average Medicare spending varies greatly from region to region. In Louisiana, average Medicare spending is over $6200 a year, but in Oregon it is only $2600 per year. Under some proposals, the differences in cost would be shouldered by the beneficiary.

There is no guarantee that these plans would have to provide certain benefits or services.

Coverage that is currently guaranteed under Medicare—such as diabetes testing supplies and mammograms for breast cancer—would evaporate under this model.

This could create a situation where low income beneficiaries might be able to afford lower cost plans that doesn't provide the health care that they need.

Under this proposal, wealthier beneficiaries, however, would be able to afford higher-cost, better quality plans.

This creates classes of health care—something I'm sure we all want to avoid.

Another problem with an FEHBP style model is that it leads to adverse risk selection.

Within the FEHBP, we have seen that the plans compete to attract lower-cost, healthy individuals.

As a result, higher cost, sicker individuals wind up in the fee-for-service plan, which is traditionally more expensive.

This places an increasing financial burden on individuals who are already sick and vulnerable.

Mr. Chairman, as I mentioned earlier, the reality is that the elderly are an expensive population to care for.

Converting Medicare to an FEHBP-styled model will do nothing to change that.

It would simply change who pays.

Thank you, and I yield back the balance of my time.

Mr. NORWOOD. And now we would like to hear from our panelists.

We have a very distinguished panel, and Mr. Jindal, if you would begin, please. Pull the microphone close to you.

STATEMENTS OF HON. BOBBY P. JINDAL, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MARILYN MOON, SENIOR FELLOW, URBAN INSTITUTE; STUART M. BUTLER, VICE PRESIDENT FOR DOMESTIC AND ECONOMIC POLICY STUDIES, HERITAGE FOUNDATION; MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE; AND STEPHEN J. deMONTMOLLIN, VICE PRESIDENT AND GENERAL COUNSEL, AVMED HEALTH PLAN

Mr. JINDAL. Thank you, Mr. Chairman, Representative Brown, and distinguished subcommittee members, I thank you for the invitation and the opportunity to appear before the committee today.

I am delighted to have the opportunity to discuss the administration's goal of giving Medicare beneficiaries reliable and attractive health care options, and lessons that can be drawn from the Federal Employees Health Benefits Program about how to accomplish that goal.

I also look forward to answering your questions. We believe that it is critical for seniors to have these options, in addition to the option of staying in today's fee for service Medicare plan, or choosing a fee for service plan with an improved benefit package.

About 5 million seniors, including many with serious health problems, choose to enroll in a private plan today and for good reasons. Through these plans, Medicare beneficiaries can obtain drug coverage, better preventive care, innovative disease management programs, and other benefits even as they lower their out-of-pocket costs.

Now, there has been a lot of discussion about the cost and the benefits of Medicare+Choice plans, but I think it is important to contrast these plans with fee-for-service, plus Medigap.

And as we know, over 90 percent of the beneficiaries have some form of supplemental coverage, and I think it is important to look at that bigger picture when making these comparisons.

As the members of this committee know all too well, however, millions of Medicare beneficiaries have only one health plan available to them, the traditional fee for service plan.

And most seniors are only given one or two other options. In recent years, flaws in the payment system for Medicare's private plans have forced many of these plans to reduce their benefits or service areas, or withdraw from the program entirely.

And I think you will hear a little bit more about that as part of the panel. While the benefits offered by the plans remaining still provide a better deal for many seniors than fee-for-service Medicare+Choice, an increasingly costly Medigap policy, millions of seniors who prefer private plans have been made worse off as a result of these changes.

And without corrective legislation, this situation will only get worse, and just at the time when rapid advances in care will make it even more important for seniors to have these options.

By contrast, Members of Congress, administration officials, and all other Federal employees, have long been able to choose from a wide variety of health plans, including not just HMOs, but more

flexible, preferred provider organizations and point of service plans as well.

Indeed, the majority of the employees in the Federal Employees Plan are actually in one of these two latter types of organizations and not in HMOs.

This system allows each participant to choose the plan that best meets their health care needs, and has given them access to innovative benefits, as well as options for reducing their premiums and health costs.

To quote the President, "Medicare beneficiaries should have the same kind of reliable coverage options available to all Federal employees throughout the country, a system that has been proven to provide one of the highest levels of satisfaction of any health care program."

Of course, Medicare's failure to provide America's seniors with reliable health care options is just one of the ways in which the program has lagged behind.

That is why the administration has also developed a framework for strengthening Medicare to address the many threats to its ability to give seniors the health service they need now and into the future.

At the same time, the President's budget recognizes that it will take several years to implement the comprehensive improvements that Medicare needs, including a prescription drug benefit that has been mentioned today, and a more equitable payment system for private plans.

Therefore, the budget also proposes urgently needed steps that should be incorporated in the Medicare legislation in order to stabilize the Medicare+Choice program. These proposals would modify the Medicare+Choice payment formula to better reflect actual health care cost increases, allocate additional resources in 2003 to counties that have only received minimum updates, and provide incentive payments for new types of plans to participate in Medicare+Choice, including PPOs.

Together, these augmented payments would address the problem of persistently low payment updates to most Medicare+Choice plans, making more plan choices available and improving benefits for millions of seniors.

Because these proposals would allow many plans to provide or to at least maintain drug coverage in their benefit package, they also provide another means of giving seniors prompt help with their drug costs so that they do not have to wait for the full implementation of a drug benefit.

I have submitted my statement for the record, and it provides additional details about these short-term proposals, and about how the administration sees FEHBP as a useful example for Medicare for providing reliable access to the kind of innovative health benefits that so many seniors want and deserve.

In closing, just let me say that the President remains fully committed to working with Congress to pass legislation this year that reflects his framework for strengthening Medicare.

He also believes that legislation should include several immediate steps to help seniors, while longer term improvements are being implemented so that Medicare legislation can provide help to

seniors who need help now, and not just a few years down the road.

I look forward to answering your questions and working with you to put into place these important enhancements for Medicare beneficiaries. Thank you, Mr. Chairman.

[The prepared statement of Hon. Bobby P. Jindal follows:]

PREPARED STATEMENT OF HON. BOBBY P. JINDAL, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Bilirakis, Representative Brown, distinguished Subcommittee members, thank you for inviting me to appear before the Committee today. I am delighted to have the opportunity to discuss the Administration's goal of giving Medicare beneficiaries reliable and attractive health plan options—and the lessons that can be drawn from the Federal Employees Health Benefits Program about how to do so. We believe it is critical for seniors to have these options, in addition to the option in staying in today's fee-for-service Medicare plan or choosing a fee-for-service plan with an improved benefit package. About 5 million seniors, including many with serious health problems, choose to enroll in a private plan today—and for good reasons. Through these plans Medicare beneficiaries can obtain drug coverage, better preventive care, innovative disease management programs and other benefits even as they lower their out-of-pocket costs.

As the members of this committee know all too well, however, millions of Medicare beneficiaries have only one health plan available to them—the traditional fee-for-service plan—and most seniors are given only one or two other options. And in recent years, flaws in the payment system for Medicare's private plans have forced many of these plans to reduce their benefits or service areas or withdraw from the program entirely. While the benefits offered by the plans that remain still provide a better deal for many seniors than fee-for-service Medicare plus an increasingly costly Medigap policy, millions of seniors who prefer private plans have been made worse off as a result of these recent changes. And without corrective legislation this situation will only get worse—just at the time when rapid advances in care will make it even more important for seniors to have these options.

By contrast, Members of Congress, Administration officials, and all other Federal employees have long been able to choose from a wide variety of health plans, including not just HMOs but more flexible Preferred Provider Organizations and Point-of-Service plans as well. This system allows each participant to choose the plan that best meets their health needs and has given them access to innovative benefits as well as options for reducing their premiums and health costs. To quote the President, "Medicare beneficiaries should have the same kind of reliable coverage options available to all Federal employees throughout the country—a system that has been proven to provide one of the highest levels of satisfaction of any health care program.'" Of course, Medicare's failure to provide America's seniors with reliable health care options is just one of the ways in which the program has lagged behind. That is why the Administration developed a framework for strengthening Medicare to address the many threats to its ability to give seniors the health security they need, now and into the future.

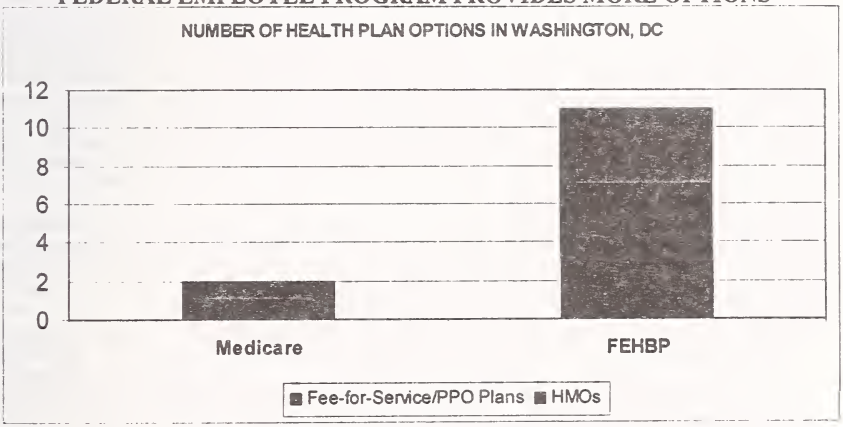
At the same time, the President's budget recognizes that it will take several years to implement the comprehensive improvements that Medicare needs, including a prescription drug benefit and a more equitable payment system for private plans. Therefore the Budget also proposes urgently needed steps that should be incorporated into Medicare legislation in order to stabilize the Medicare+Choice program. These proposals would modify the Medicare+Choice payment formula to better reflect actual healthcare cost increases, allocate additional resources in 2003 to counties that have received only minimum updates, and provide incentive payments for new types of plans to participate in Medicare+Choice, including PPOs. Together these augmented payments would address the problem of persistently low payment updates to most Medicare+Choice plans, making more plan choices available and improving benefits for millions of seniors. Because these proposals would allow many plans to provide or at least maintain drug coverage in their benefit package, they also provide another means of giving seniors prompt help with their drug costs—so that they do not have to wait for the full implementation of a drug benefit. But before I provide additional details about these short-term proposals I would like to explain how the Administration sees FEHBP as a useful example for Medicare in providing reliable access to the kind of innovative health benefits that so many seniors want and deserve.

PROVIDING RELIABLE HEALTH INSURANCE OPTIONS FOR SENIORS

For more than 36 years, Medicare has been immensely successful in helping America's seniors achieve the promise of secure access to needed health care. During that time, medical practice has improved dramatically, but the Medicare benefit package and delivery system have not kept pace. Medicare's lack of prescription drug coverage is only one example of the ways in which the program has become outdated. Medicare has also lagged behind the private sector in providing reliable health insurance benefit options for beneficiaries that best meet the beneficiaries' own circumstances and preferences. Like the Federal government, many state governments and most large private employers help their employees get the care that is best suited to their needs by offering them several health care plans, along with unbiased and useful information that helps them choose the best one. But Medicare has failed to provide America's seniors with the same kind of reliable health care options that every Federal employee has received for decades. For many beneficiaries, particularly those in rural areas, Medicare offers only one insurance plan—it is strictly one-size-fits-all. Previous legislation to address this problem, including the establishment of the Medicare+Choice program, has not had the intended effect of providing more reliable health insurance options for Medicare beneficiaries.

The effects of Medicare's current shortcomings can be seen very clearly here in our Nation's capital (and in the figure below). Those of us who are Federal employees living in Washington, DC, have eleven different health plans to choose from, including a variety of fee-for-service plans and health maintenance organizations (HMOs). But our neighbors with Medicare coverage have only two choices—the traditional fee-for-service plan and a single HMO. This pattern occurs throughout the country, in urban and rural areas alike. Park Rangers living in the most remote national forests, and postal workers in every neighborhood, have at least seven plan choices. Overall, FEHBP provides health insurance coverage to 9 million workers and their families through contracts with almost 180 insurers and health plans.

FEDERAL EMPLOYEE PROGRAM PROVIDES MORE OPTIONS



Private plans like those offered to Federal employees have long been the choice of millions of Medicare beneficiaries because these plans allow beneficiaries to receive more up-to-date benefits than those available under traditional Medicare. Private plans will be the preferred option for many seniors for several reasons:

- Private plans often have provided innovative new health benefits—including preventive care, prescription drug coverage, and dental services—without having to wait for an act of Congress. Private plans also invented state-of-the-art coordinated care for the many Medicare beneficiaries who have multiple or chronic health problems.
- Private plan options allow seniors to reduce or eliminate their co-payments and deductibles so that their out-of-pocket payments are manageable—without having to purchase a supplemental insurance policy that provide expensive "first dollar" coverage.
- Private plan options give seniors more power. If they are not happy with the service they are receiving, they can switch to a different plan. Competition is the best way to make bureaucracies and health plans responsive—by giving cus-

tomers the freedom to choose. Medicare beneficiaries should have the same options as working Americans.

For these reasons the President's framework for strengthening Medicare includes the principle that Medicare's coverage should be improved to give beneficiaries the same kind of reliable health care options and access to innovative benefits that all Federal employees and many other Americans enjoy. As in the Federal employees' program and other successful programs:

- Plans should be allowed to bid to provide Medicare's required benefits at a competitive price, and beneficiaries who elect a less costly option should be able to keep most of the savings—so that a beneficiary may pay no premium at all.
- Medicare's payment system should create a level playing field for all plans in areas where private plans are paid less today and should continue to encourage private plans to participate in areas where Medicare provides few choices.
- The improved choice system should give beneficiaries useful and timely comparative information on the quality and total cost of all of their health care coverage options. Administrative burdens on private plans should be reduced while protecting patients' rights to allow good insurance plans to focus on providing reliable, high-quality service for Medicare beneficiaries.
- In areas where a significant share of seniors choose to get their benefits through private plans, the government's share of Medicare costs should eventually reflect the average cost of providing Medicare's required benefits in the private plans as well as the government plan. Low-income seniors should continue to receive more comprehensive support for their premiums and health care costs.

At the same time, many Medicare beneficiaries will prefer to stay in the government-run, fee-for-service Medicare plan. The President's framework preserves the option of staying in the existing plan, with no changes, for seniors who prefer what they have now. It also provides an improved government plan option with better preventive coverage, better protection against the high costs of serious illnesses, and more affordable Medigap coverage.

STRENGTHENING MEDICARE+CHOICE NOW

Clearly, a comprehensive set of improvements to Medicare will take time to implement. Such improvements must include giving all seniors the option of subsidized prescription drug coverage. They must include giving all beneficiaries better options to reduce their costs and obtain better benefits in a private plan. But because so many beneficiaries value the benefits they obtain through Medicare+Choice—and because it is so important to retain these options for the future so that seniors have access to the valuable and innovative new benefits that private plans can provide—we need to take steps now to encourage private plans to remain in Medicare until the new payment system is phased in.

Medicare+Choice has enabled us to take advantage of private sector expertise to give Medicare beneficiaries more services for their premiums, often with lower cost sharing and more benefits than are available under traditional Medicare. It is important to recognize that these plans provide many benefits that are valuable to seniors with serious and chronic health conditions. For example:

- A Medicare+Choice plan in Boston instituted a comprehensive disease management program for its enrollees with diabetes. The result has been significant increases in the share of enrollees who received annual retinal eye exams and are monitored for diabetic nephropathy and substantial improvements in the management of their Hemoglobin and cholesterol levels.
- A Medicare+Choice plan in Florida instituted a comprehensive disease management program to monitor, facilitate, and coordinate care for enrollees stricken with cancer. As a result, the number of acute hospital days per cancer case dropped by about 15% over two years and the share of inpatient admissions for complications with cancer has declined by 10 percent.
- Research has shown that individuals who receive after-care following hospital stays for mental illness are more likely to be compliant with their treatment regimens and less likely to be readmitted to the hospital. One Medicare+Choice plan in New York instituted a case management program for those hospitalized for mental health disorders and nearly doubled the share of its enrollees who received follow-up care within 7 days of their hospital discharge.
- A Medicare+Choice plan in California established a successful outreach program to increase influenza vaccination rates among their elderly and chronically ill beneficiaries in order to reduce mortality and morbidity among these at-risk populations.

As you know, the Medicare+Choice program has changed significantly in the last several years. Hundreds of plans have left the program or reduced their service

areas affecting hundreds of thousands of beneficiaries. In 2002, about 60 percent of all Medicare beneficiaries have access to a Medicare+Choice option, compared to 74 percent in 1998. This year, more than 500,000 beneficiaries were impacted by organizations either withdrawing from the program or reducing their service areas. Plans with both zero premiums and no significant beneficiary cost sharing have largely disappeared. In addition, plans are less likely to offer drug coverage in their basic plan and even when they do that coverage has become less generous. As a result, the share of enrollees with drug coverage in their basic plan declined from 84 percent in 1999 to 69 percent in 2001. This is because the annual increases in Medicare+Choice payments in the counties where most enrollees live have failed to reflect rising health care costs. Unfortunately, as a result, plans that wish to stay in the program are left with two options: reducing supplemental benefits or increasing beneficiary cost sharing.

In 2001, the Administration took a number of actions to reduce administrative burden on Medicare+Choice plans so that they could focus on providing care to their enrollees. Secretary Thompson and Administrator Scully have testified about these administrative actions before this committee and the other committees of jurisdiction. The Secretary's regulatory reform initiative will also address the regulatory burden on Medicare+Choice plans. As the Secretary asked when announcing this initiative, "At the very time when we are trying to attract more managed care plans to offer their services to Medicare beneficiaries, do we really need 854 pages of regulations standing in the middle of the front door to the program?" Here the contrast with FEHBP—where high levels of enrollee satisfaction have been achieved by contracting with health plans to provide good options and using regulations only to the extent necessary—is also striking.

But more must be done and that will require legislation. Despite our best efforts to slow the number of plan withdrawals through administrative actions, it is apparent that additional improvements need to be made to the Medicare+Choice program to encourage more plan participation and greater beneficiary access to Medicare options. Simply put, the Medicare+Choice payment system must be more responsive to the health care marketplace, so that the program can meet beneficiary needs. We support a fairer payment system for private plans in Medicare because the current payment system is causing many seniors to lose access to valuable benefits—and if left uncorrected this problem will only get worse just as the need to keep up with rapid advances in medical benefits is growing.

Congress has acted to increase funding for Medicare+Choice through legislation in recent years, but much of the increase was targeted to so-called "floor" counties. As a result, these counties have experienced cumulative average payment increases of 50 percent over the last five years. Specifically, the floor payment amount, which is the payment received in many rural areas, increased from $415 to $475 in 2001 and $500 in 2002.

However, payment increases for private plans have failed to stay anywhere close to medical cost increases in many parts of the country—the so-called "non-floor" counties that have accounted for the vast majority of Medicare+Choice enrollment. Between 1998 and 2002, private plan payments in many of these areas increased by just 11.5 percent while Medicare fee-for-service payments (government plan costs) went up by about 17 percent nationwide—about 50 percent faster. This is the reason many plans cite for having to cut benefits, raise copayments, and even pull out of the program-creating serious problems for the beneficiaries who depend on them.

This year, the President's budget focuses on increasing payments in these "non-floor" counties. Under the budget proposal:

- For 2003, M+C payments would be increased by 6.5 percent in counties that received the minimum update in 2002 and by overall Medicare growth minus 0.5 percent in "floor" counties.
- For 2004 and 2005, the minimum update and floor rates would be increased by overall Medicare growth minus 0.5 percent. The payment would be the greater of these rates or a blended rate.
- Reforms to payments for private plans for 2006 and beyond would be part of the comprehensive improvements in Medicare envisioned in the President's framework.

The budget also proposes to give bonus payments to coordinated care plans that are the first of their type (i.e. HMO or PPO) to enter a service area. During their first year in a new service area, eligible plans would receive a 5 percent bonus on top of their M+C per member per month payment. The bonus would phase out 1 percent per year over the plan's first five years of operation. This proposal would expand the number of health plan options available to Medicare+Choice enrollees by broadening the variety of plans that participate in the Medicare+Choice program

to include the types that beneficiaries want, and are available to Federal employees. For example, this proposal would give preferred provider organizations (PPOs) an incentive to enter service areas that already have a Medicare+Choice HMO.

We believe that the investments proposed in this budget will encourage new plans to enter Medicare+Choice and will improve the coverage options available to millions of beneficiaries. Even with all the problems caused in recent years by the current payment system, there are still over 5 million Medicare beneficiaries enrolled in private plans—so for many seniors, private plans are the best option. Indicators of care quality and enrollee satisfaction in these plans are high. And even after the recent cutbacks in benefits, they can still be a better deal for seniors than enrolling in traditional Medicare and buying an expensive supplemental policy to cover the large benefit gaps.

CONCLUSION

The President remains fully committed to working with Congress to pass legislation this year that reflects his framework for strengthening Medicare. He also believes that legislation should include several immediate steps to help seniors while longer-term improvements are being implemented—so that Medicare legislation can provide help to seniors who need help now, not just a few years down the road. I look forward to answering your questions and to working with you to put into place these important enhancements for Medicare beneficiaries.

Mr. NORWOOD. Ms. Moon, you are now recognized, please, Madam.

STATEMENT OF MARILYN MOON

Ms. MOON. Thank you. I appreciate the opportunity to be here to speak to the committee, and in my testimony, I spend a considerable amount of time talking about the value of competition and choice.

I should indicate that I am a trained economist, and I believe fairly in competition and choice, but I believe you also have to be very careful about the market that you are dealing with.

And in the case of health care, the health care market puts up a number of problems that make choice not necessarily work quite as well. Most capitated programs that we see out there now have not generated the innovative ways to organize care that many people anticipated and hoped would happen in a capitated system.

But instead they have concentrated on doing the things that are the easiest to do in the case of running a good program, and that is enrolling healthy beneficiaries, and using relatively crude controls on service use.

In fact, if you enroll healthy beneficiaries, you can look right to those who enroll, because you are offering them terrific benefits, and you are offering them good coverage. The problem is that it is just not very good for society as a whole nor for the Medicare program because you are skimming off the easiest to deal with patients in that setting.

Part of that occurs because we have moved from a capitated system, and from a fee for service situation which does have problems, to one in which we simply give people a fixed payment and say go out and do good without a lot of oversight and control.

Competition then can lead to a number of problems for beneficiaries, including instability in the case when plans leave, when physicians leave the program, when other problems occur, which is particularly a problem for the vulnerable beneficiaries and leaves them at risk.

The choice of plans will also not offer many advantages for beneficiaries, particularly since this election is a big problem out there

and not one that we have dealt with. Mostly people talk about improving risk selection have problems and adding a risk adjustor, in terms of the promise of risk adjustment, as opposed to the practice.

Competition and choice can make it difficult to protect the social insurance nature of the Medicare program. Now, if you look at some of the practical issues in moving to an FEHBP type approach, there are also a number of issues that I think should be considered very carefully if you want to move in this direction.

First, I think it is important to emphasize that extra benefits, including prescription drugs, cannot be provided without substantial additional Federal resources. Flexibility in the payment system is simply not going to do it in an environment in which we already have an inadequate benefit package.

It is difficult to imagine, for example, what tradeoffs could be done in a package of benefits that would compensate plans for providing prescription drug benefits if they have to then raise cost sharing to a very high level, and other services in the program.

Rising costs have been a greater problem for FEHBP than Medicare as someone has already mentioned in recent years, likely because all of us are facing problems when we look at the health care system and holding down costs, and managed care plans are certainly no exception.

Withdrawal of the plans from participation have also plagued both Medicare and FEHBP. So I think it is hard to imagine that we can solve some of the problems in the Medicare+Choice system by simply moving to FEHBP.

And finally the costs of administering an FEHBP type system could be high under Medicare because of the individual enrollment nature of the program. You don't have the backup of the Federal Government with its personnel offices to help in many cases.

We would need to have greater oversight for vulnerable beneficiaries, and a challenge of a much larger enrollee base, and a more complicated enrollee base, both in terms of the health of the enrollees, and in terms of the geographic variations, and the rural area problems, versus folks who live in cities, and trying to deal with that all under one rubric.

So I conclude with a number of next steps for modernizing Medicare. I strongly believe that we must add a prescription drug benefit as a first step, and not a last step, in part because you cannot have good fee for service, good managed care, or a good much of anything else until you have prescription drugs in the benefit package.

Much more is needed to be done on risk adjustment and that is the key if we want to move to more privatization, I believe. We need to focus on improving fee for service, even if you offer a number of other plans.

Fee for service will remain very popular for Medicare beneficiaries for the time to come, and I think there are innovative ways from the private sector that you could layer on to the fee for service part of Medicare in terms of coordination of care, for example.

Don't assume that privatization gives beneficiaries what they want. They all say they like to have choice, but they mean choice

of physicians and hospitals, and they are often very confused and frustrated by the complications in the Medicare+Choice system.

And don't assume that regulation and oversight will be simpler with competition, because this is a population that needs a lot of oversight and protections. I would urge the Congress to expand that with an improved Medicare+Choice, because I do agree that having a variation is good.

It is healthy for some competition between the public sector and the private sector, but I think we should move slowly in this direction. And finally I think it is important to recognize that Medicare will need more resources in order to be a viable program for the future. Thank you.

[The prepared statement of Marilyn Moon follows:]

PREPARED STATEMENT OF MARILYN MOON, THE URBAN INSTITUTE

Supporters of using a Federal Employees Health Benefits Program (FEHBP) model for reforming Medicare often tout three major advantages: competition that will bring innovation and take the federal government out of the business of setting prices, choice for beneficiaries selecting plans, and savings to the federal government. Who could be against such a "mom and apple pie" proposal that achieves these outcomes? After all, wouldn't a private sector, capitalist approach be preferred over a public program such as the current traditional Medicare fee for service system? For a number of reasons, I argue that privatization of Medicare can be disadvantageous to beneficiaries of the program, failing to achieve all or most of these advantages and creating additional risks. A go-slow approach to revising the role of private plans in Medicare makes more sense than a rapid move to privatization.

In my testimony I examine the claims regarding advantages from the private sector and put them in the broader context of meeting beneficiaries' needs. In addition to looking at the issues surrounding the economic incentives that are the heart of the argument for privatization, it is also useful to consider experience both with the current Medicare+Choice program and the Federal Employees Health Benefits Program (FEHBP). I conclude my testimony with a set of recommendations aimed at protecting the interests of beneficiaries as Medicare evolves to meet Americans' 21st Century needs.

THE ELEMENTS OF AN FEHBP APPROACH

To resemble FEHBP, Medicare would have to change in a number of ways. Under FEHBP, all plans compete for enrollees; they each offer premiums that vary and some differences in deductibles, co-payments and other benefit characteristics. The federal government pays a portion of the premiums according to a formula, where the goal is to require that individuals who choose higher-cost plans pay a greater monthly premium than those choosing lower-cost plans. The idea is to encourage plans to compete on the basis of price and to give those enrolling a stake in choosing less expensive plans. Individuals can change plans once a year during open season; plans can also change their offerings at that time, if approved by the Office of Personnel Management.

While the various characteristics of a Medicare version of this approach could differ, proponents usually cite a number of components as key. Requiring that individuals choose a plan (even those who wish to keep the traditional fee-for-service option) and pay more if its total premiums are higher than an average amount is intended to make Medicare beneficiaries more sensitive to differences in health care costs. Offering multiple plans in a geographic area, including managed care options, is also usually part of such proposals for Medicare. The key is to use economic incentives to spur competition and choice for beneficiaries.

COMPETITION AND CHOICE

Competition and choice are so often cited as desirable, however, that what they mean in the context of health care is rarely even discussed. Thus, it is useful to consider if and why they might be desirable. First, the goal of competition is to raise quality and reduce costs so as to attract customers. In theory, this indirect enforcement mechanism should reduce the need for direct oversight and regulation in a well-functioning market since competitors effectively police each other. Choice is a related "good" because it allows the market to test for what consumers want and

presumably, over time, products will change to more closely reflect consumer preferences. Choice also allows for differences in competing products and, hence, avoids the "one size fits all" approach that can result in a single product that no one likes.

Economic incentives can influence behavior in the healthcare market place just as they can for other types of goods and services. But, the health care market does entail unique problems and constraints that need to be taken into account. Further, some traditional incentives may not be appropriate in light of other goals such as societal concerns about access to care and the quality of basic care.

First, consider competition. The real issue facing Medicare's future is not the theoretical attractiveness of competition, but what it means in practice for the delivery of care. How does competition among private plans manifest itself? If we were dealing with a very standardized product, competition should only affect the quality of the product and its price. But when there is little standardization and few norms for quality—as is the case in health care—quality bears little relationship to competition. Furthermore, in neither Medicare+Choice nor FEHBP is competition focused exclusively on price. Offering alternative benefit packages is the major way in which Medicare+Choice plans compete, and this idea underpins FEHBP's structure as well. It is hard to lower costs while allowing a number of options to be proffered.

But when price is an issue, good competitors look around and seek the easiest ways to hold down costs to lower their prices. In insurance plans, such as found in Medicare+Choice, the easiest path to profitability is to attract a healthier than average mix of patients (unless there is a good payment system that provides incentives to accept sicker patients). This happens not because plans are evil or cruel, but rather because they must make a profit. By seeking healthier enrollees, they can offer their clients a rich mix of services, do well by them and still make a profit. This is good for the company and good for their clients. It is just not good for sicker beneficiaries, for the Medicare program, nor for society as a whole because insurance companies end up getting paid too much for the clients they serve. Can that be altered? Creating a very strong risk adjustor could reduce, but probably not eliminate, the incentives to skim the cream from the market. Further, the existing risk adjustors are weak and progress on improving them has been very slow.

The second way that plans may be able to hold down costs is by obtaining discounts from care providers. Further, supporters of competition often point to the benefits of letting insurers deal with the many prices that need to be set to have health care operate under the traditional Medicare program. Relying on private insurers does not solve that problem, however, but simply moves it to the plan level. Micromanagement would be eliminated at the federal government level, but would be alive and active within the insurance company.

One way or another, the health care market has to contend with administered or negotiated prices. In the case of private plans, health care providers are now striking back with demands for higher fees. If plans enter into long, contentious negotiations, the network of doctors and other care providers participating in a plan may become smaller and less stable, an outcome that hurts consumers.

A competitive environment may also reduce stability for consumers and providers in another way. As plans themselves move in and out of markets, some consumers may lose access to their physicians and other providers and have to learn a new set of rules if they go to another plan. These changes hurt the continuity of care.

Developing innovative and effective tools for reducing unnecessary care is often well down the list of insurers' preferred strategies to reduce the costs of covering Medicare beneficiaries. In practice, such cost-controlling activities are hard to implement, especially for plans that consist of very loose networks of hospitals and doctors. It requires considerable effort and resources to build an infrastructure to coordinate care effectively. Some plans have used cruder methods—making it hard to get appointments or routinely denying certain types of care—but this approach is a far cry from good management and is one that has helped fuel the backlash against managed care plans. Thus, one of the hopes for managed care—that it would use new and innovative strategies to better curtail unnecessary service—has not been achieved.

These limitations on competition mean that private plans can hold down the costs of health care only modestly. Expectations by competition proponents that the savings achieved would be great enough to pay for substantial additional benefits at little or no cost to either the government or beneficiaries has been one of the rationales for supporting such an approach. But even if competition lowers costs somewhat from restricting provider choice and limiting care, savings may be insufficient to pay for expensive benefits like prescription drugs. Given the barriers to competition in this market, the promise of substantial savings has been seriously overstated.

What about choice in health insurance? Is this so important to consumers that it justifies adopting a competitive, private market approach? Here it is important to note that choice issues tend to be thought of in two very different ways. For those enrolled in Medicare, choice is valued when it means the ability to pick one's own doctor or health care provider. To the health economist, choice usually refers to inviting competition by letting consumers choose among plans. But, the first type of choice is often restricted by plans, which offer limited supplies of providers and no guarantee that providers won't change over the course of a year. That aspect of choice thus offers a disadvantage to consumers.

Yet, one potential advantage of choice among plans would be to allow individuals to seek policies that cover only the care that they believe they will need—for example, by excluding certain services (such as home health care) or offering higher deductibles and co-pays. But this flexibility creates a major problem since healthy people can choose a plan with high deductibles or no home health care, most likely putting them into a risk pool that does not attract those in poor health. And if high and low users of health care are not in the same risk pools, then sicker beneficiaries will have to choose among very high premiums costs or limited insurance coverage. And particularly if the risk adjustor that sets payments to plans on behalf of individuals of varying health status is weak, it is essential to limit choice in order to also limit risk selection.

As noted above, another major problem with giving consumers choice of benefits is that it results in a different type of competition than price competition. Beneficiaries would not necessarily choose the lowest cost plan under such a strategy. If true competition were the goal, benefits would also be standardized to assure greater comparability and price comparisons.

What does choice mean when benefits are standardized? Presumably individuals would choose among plans with fixed benefit packages. But on what basis can they make good choices? Plans are likely to advertise why they should be chosen, but they may not provide very helpful information. And the information that people really need, such as what different plans establish as "reasonable payment levels" or define as "medical necessity," is usually considered proprietary. But these seemingly technical issues determine what services are actually covered. Even if this information were made available, it is very hard even for savvy consumers to compare plans. Often, choosing the wrong plan becomes obvious only when the client becomes sick and needs care. Neutral advice and information from government can help consumers choose, but will that be enough to improve health coverage? And will the government invest in the dissemination of the objective data? Numerous studies have documented the problems and discomfort that many beneficiaries experience in trying to make such choices.

For these reasons, I conclude there is little to be gained from expanding competition and choice for the beneficiary at the present. Competition does not offer a panacea. People need to look beyond the buzzwords and weigh the tradeoffs. The risks of dividing Medicare into the sick and the healthy in the name of competition and choice are high. And the potential for undermining the basic goals of Medicare as an entitlement program also argue against relying on private sector initiatives. Assuring universal access to care for those who are eligible is an important precept of Medicare. Splitting up the risk pool and relying on the private sector, which has no stake in social goals, make it difficult to protect the program.

EXPERIENCE WITH MEDICARE+CHOICE

High quality plans seeking to serve patients well certainly exist, but Medicare+Choice is a very troubled program. Medicare has, since the 1980s, formally allowed beneficiaries to choose private plans (paid on a capitated basis) instead of remaining in the traditional fee-for-service part of the program. In 1997, the Balanced Budget Act (BBA) modified the private plan option to allow plans other than health maintenance organizations (HMOs) to participate. The new option was called Medicare+Choice.

The BBA also sought to reform the payment system, which costs Medicare more for each enrollee than if they had remained in the traditional program. Serving a healthier population and lacking an adequate structure for establishing payments, Medicare overpaid its private plans for the cost of Medicare-covered services. But the new payment system has not solved the problems of overpayment; rather, it has created new ones.

Medicare's rules require that if a plan is paid more than it costs to provide Medicare-covered services (and a normal profit), the plan must either return money to the federal government or offer additional benefits to plan participants. Almost all offer extra benefits; in fact, many plans believe that they must do so to attract en-

rollees. Thus, even after several years of lower payments from the BBA changes, the General Accounting Office found in 2000 that Medicare+Choice plans used 22 percent of their revenues to provide additional benefits beyond what is required by Medicare. Further, Medicare's benefit package is recognized as not very comprehensive, making it difficult to manage care without covering other benefits such as prescription drugs.

Although Medicare's payments have been sufficient to pay for Medicare-covered services, plans now have fewer dollars to offer extra benefits than before. Over the past four years, as Medicare's contributions to plans have become less generous, extra benefits have been substantially reduced and plans have exited some markets. Withdrawals have left hundreds of thousands of beneficiaries scrambling each year to enroll elsewhere or to get Medigap coverage if they return to traditional Medicare. Further, plans with drug coverage have declined from 84 percent of all plans in 1999 to 71 percent in 2002. And when drug coverage has been retained, stringent caps have been applied or substantial premiums levied on the beneficiary. By 2002, almost two-thirds of enrollees in M+C plans had either no drug coverage or coverage limits of $500 or less.

Both plans and beneficiaries had come to expect the extra benefits that could be offered under the pre-1997 payment levels, and the decline in benefits has disappointed and disillusioned many beneficiaries. In that sense, plans are correct that they are not paid enough to offer an "attractive" benefit package. Should extra federal dollars be used to assure such extra benefits in M+C but not in traditional Medicare? The 86 percent of beneficiaries in traditional Medicare are unlikely to favor such a policy change. But without further federal dollars, enrollment in Medicare+Choice will likely decline further.

Are the problems noted here with Medicare likely to be present under any managed competition arrangement, or are they peculiar to Medicare+Choice? Most likely, many of the issues now facing Medicare+Choice will be present under any system relying on private plans. In particular, adverse risk selection can affect any managed competition arrangement that does not effectively adjust for population differences. It takes only a small amount of risk selection to destabilize the Medicare program, if a large number of beneficiaries have known health problems since their own choices may contribute to risk selection. The lack of reliable information on choices and the absence of good coordinated care are also likely to remain problems.

The size and nature of the benefit package is also likely to plague Medicare in the future unless the basic benefit package is improved. Since Medicare lacks prescription drug coverage, payments to plans will not cover this expensive benefit, even thought it is hard to imagine how managed care (or fee for service) can function without such coverage.

At the same time, the administered prices used in Medicare+Choice have create some unique problems, including payments set unnecessarily high or low in response to geographic differences in health care spending under fee for service. But no new payment system has come along that promises to work any better.

Finally, regulatory reform and simplification could help to make a new Medicare approach more attractive to potential participants. This overhaul needs to be carried out in the context of recognizing the special vulnerabilities of some beneficiaries in Medicare, however. There has not been an impartial assessment of the proper balance between beneficiary and provider interests.

BORROWING FROM FEHBP

The Federal Employees Health Benefits Plan has a number of problems of its own that would likely carry over if it became the new template for Medicare. Perhaps most important, the attractiveness of FEHBP in holding down the costs of care has diminished considerably since the mid 1990s, when that approach enjoyed greater success than Medicare. Since then, the rate of growth in spending on FEHBP has been very high. Although results vary with the period examined, traditional fee-for-service Medicare has done considerably better than FEHBP (see Figure 1). Further, in the past several years, deductibles and co-payments required by both managed care and PPO plans have risen substantially. These trends suggest that an FEHBP model for Medicare cannot be expected to lead to improved benefits without substantially higher payments from the federal government.

For this reason, one of the few aspects of FEHBP that Medicare beneficiaries would find appealing—prescription drug coverage—would not magically arise without higher federal spending. The estimated cost of such a benefit (based on the average level of FEHBP coverage) would be $750 billion over ten years. Proponents of an FEHBP-type system have argued that it is better not to have fixed benefits, as

under Medicare, but rather to let benefit packages evolve over time. But if the money is not there, benefits will not be there either. And Medicare's benefit package is not generous enough to allow much leeway for benefit package tradeoffs.

The troubling plan withdrawals that have plagued Medicare+Choice have also occurred at nearly the same rate in the federal employees program. While FEHBP offers more plans than M+C and plan participation in Medicare peaked later, the withdrawal patterns look quite similar (Figure 2). Further, FEHBP has had risk selection problems over the years. A number of the plans that offered more generous benefits and fewer restrictions had to raise premiums so much that doing business became impossible. Those plans pulled out of the market, requiring enrollees to make new arrangements. Now, as a consequence, even though plans can offer varying benefits, all the packages tend to look a lot alike.

Some of the characteristics of FEHBP that would be new features for Medicare may not be in beneficiaries' interest, even if they work well for federal employees. Many analysts have concluded that any major savings that could be achieved if Medicare were revised using an FEHBP model would come from the differential in the premiums charged, particularly for those who wish to remain in traditional fee-for-service Medicare. If premiums for the fee-for-service option rise dramatically over time and become harder to afford, as some expect, choice for many beneficiaries would be reduced, not increased. Compared to federal employees in FEHBP, a much higher proportion of Medicare beneficiaries are low income. Although special protections for low-income beneficiaries could be added, this would lead to an even more complicated Medicare system, and even then, many needing help would not qualify.

A related factor is the cost of administration. An FEHBP-type model entailss administrative costs both at the federal and plan level. The federal government would need to oversee plan participation, enrollment, payment and quality of care. Insurance offered to individuals includes substantial administrative costs to pay for marketing and management. Unlike FEHBP, Medicare has no employer base to help cover many of these functions. Thus, any savings generated by competition will be at least partially offset by higher administrative costs.

And, in another way, an FEHBP model might not always work well with Medicare and the population it serves. Under the FEHBP payment approach, plans negotiate with the federal government for the premiums that they will charge. FEHBP, as an employer-sponsored insurance program, resembles other insurance plans for workers and gives FEHBP a benchmark for assessing the reasonableness of the premiums. Since there is no full market for health insurance for people 65 and older for the government to use to compare premiums, it will be difficult for negotiators for Medicare to know what is reasonable in a given geographic area. Moreover, Medicare covers 40 million people, at least one-third of whom have substantial health problems. Sheer numbers and geographic variability make negotiation a major challenge.

Geographic variation for Medicare is also much greater than under FEHBP. For one thing, large numbers of beneficiaries reside in rural areas. Accordingly, concerns about how high to set payment levels and whether viable competition can be fostered in rural areas need attention.

Private plans would likely favor the less regulated environment of FEHBP. Any new Medicare private plan option should reduce unnecessary regulation and control, but it will still be important to keep plans accountable to both the government and beneficiaries. Medicare beneficiaries do not have workplace benefit managers to help resolve disputes with plans and vulnerable beneficiaries could be placed at considerable risk unless there is adequate oversight.

Considerable attention is needed to improve Medicare for the future. But switching to an FEHBP model offers neither a magic bullet nor a quick fix. Indeed, it might create more problems than it solves.

NEXT STEPS IN MODERNIZING MEDICARE

Whatever the structure of reform, a number of modernization issues need to be addressed:

- **Add a prescription drug benefit as a first step.** Prescription drugs are essential to the delivery of care, particularly in efforts to effectively manage care and to prevent higher costs over time. Fee for service, competition and managed care approaches cannot work if the benefit package lacks this crucial ingredient.
- **Do more work on risk adjustment.** Without a good mechanism for rewarding insurers for taking sick patients, plans will continue to serve the healthy and won't focus on better ways to provide care to the most vulnerable beneficiaries.
- **Improve fee for service.** For a very long time to come, fee for service Medicare will serve most beneficiaries. New and innovative ways of coordinating this care

need to be found. The demonstrations under way are one positive step, but more needs to be done on a small scale to compensate physicians and other current care providers to do basic coordination of care.

- **Don't assume that privatization gives beneficiaries what they want.** The complexity and confusion that arise from choice of plans annoys and frustrated many older Americans. They do not respond well to price competition and they do not want to rethink their insurance coverage every year. The one-third of all beneficiaries in poor health especially need uninterrupted care.
- **Don't assume that regulation and oversight will be simpler under an FEHBP approach.** The more flexibility and variability allowed by private plans, the more important it will be to offer protections for vulnerable beneficiaries. Geographic variation in availability of plans would likely mean different systems in place depending upon the level of competition that emerges. And substantial resources would need to be devoted to improving education and support for beneficiaries who must make choices.
- **Experiment with and improve Medicare+Choice.** The payment system needs to be reformed and adding drugs to the benefit package would add some resources. But do not assume that private plans can do everything, particularly until better risk adjustment is more than a promise.
- **Recognize that Medicare will need more resources.** No reform can succeed if too much pressure is placed on it to generate large savings. As an important program serving one in every seven Americans, Medicare will soon serve one in every five. We need to be willing as a society to provide for this vital program's future.

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Figure 1
Average Annual Increase in FEHBP Premiums and Medicare Per Capita Spending, 1998-2002

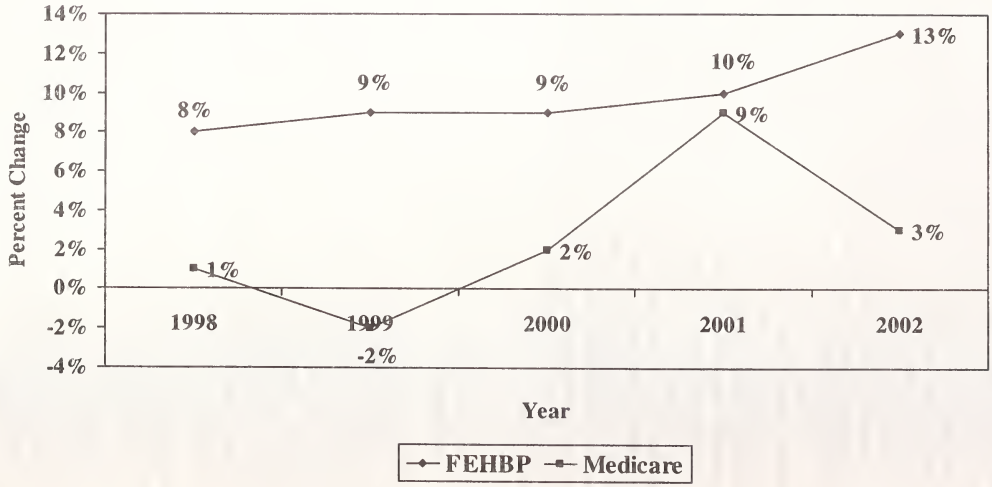
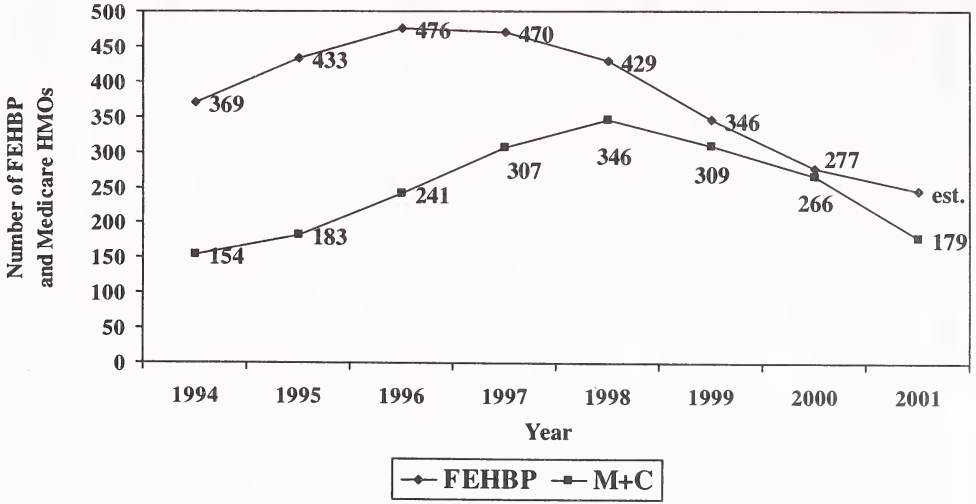


Figure 2
Number of HMOs Participating in FEHBP and Medicare+Choice at the Beginning of the Plan Year



Source: GAO analysis of OPM data; Kaiser Medicare Chart Book

Mr. NORWOOD. Mr. Butler, you are now recognized.

STATEMENT OF STUART M. BUTLER

Mr. BUTLER. Thank you, Mr. Chairman, for the opportunity to testify on the FEHBP as a model for Medicare reform. As you know, in recent years, there has been a good deal of interest in Congress regarding the way in which FEHBP operates, and I share the view that it provides important design lessons for reforming Medicare.

In my remarks, I would like to highlight some important differences between the FEHBP and the Medicare program, and then suggest aspects of the FEHBP that Congress should consider as part of the Medicare reform.

The FEHBP and Medicare are of course both run by the government. FEHBP is not privatized any more than Medicare is privatized, because it actually pays private doctors, and for many years it incorporated private plans, many of which of course provide benefits that are unavailable in the fee-for-service sector.

But these two programs are run by the government in very different ways. For one thing, the FEHBP does not require plans to offer a comprehensive standard benefits package. Instead the law requires broad classes of benefits to be included.

And only under the Clinton administration did the government add a significant number of required benefits, prompting I should point out a number of plans to leave since 1996 which has been mentioned.

And yet over the years the typical plan offered to enrollees has kept up with a comprehensive plan in the private corporate sector. There are two reasons for this. The first reason is that the plans are forced by competitive pressure and consumer demand in the FEHBP to keep improving their products.

All FEHBP plans contain drug benefits, drug coverage, and catastrophic protection, for instance. Not because they are required to, but because customers would not select them if they did not contain these common benefits.

The second reason for the range of excellent plans, however, is that the Office of Personnel Management which runs the FEHBP, negotiates benefits and premiums with the plans, as well as marketing areas and other features of plans.

This process, which is also shaped by the realities of the marketplace, leads to a range of prices and plan benefits. What OPM does not do in contrast to Medicare is to set down a detailed standardized benefits package and provide a payment formula.

There are several other differences between the way in which these two programs are run by the government, affecting such things as information distribution and payment arrangements. I discuss these in my written testimony.

But there is one final thing that I want to emphasize about OPM's role in the FEHBP. Unlike CMS, OPM does not directly manage one of the competing plans. OPM does keep its focus on establishing the best possible system of information and plan choices for beneficiaries.

How could the affected features of the FEHBP be applied to Medicare. I believe in at least three ways which I would urge the

committee to consider. First, Congress could create a new Medicare Board as several people have proposed.

This would be within HHS, and it would focus on the broad operation of Medicare, including such things as customer information and the broad environment in which the managed care plans and the fee-for-service program would compete.

But the board would not directly run the fee-for-service system or any plan. That function would remain within CMS, which could then focus more intensively on that task, and the CMS staff would be given greater flexibility to run that part of the program.

Second, the Medicare board could be given powers to negotiate the plans over premiums and services as OPM does with FEHBP plans. This process would give Medicare far greater flexibility to balance costs and service goals than is available to CMS today.

With so many plans and doctors pulling out of Medicare, I believe that Congress urgently needs to introduce more flexible negotiating powers in this way. Third, Congress could consider a modified version of the FEHBP's process of fostering gradual benefit evolution.

I suggest two parallel steps. The first would be for Members of Congress to try to get out of the business of trying to be experts on medical procedures. You could do this by setting broad categories of required medical benefits for each plan, and perhaps a minimum package of services, rather than legislating a detailed comprehensive package.

Detailed benefits should be negotiated between a board that I have proposed and the plans. The second step would be to create an expert board or council charged with proposing each year refinements to the basic package required in managed care plans, as well as the more comprehensive benefits package offered by the traditional fee-for-service program.

This council or board could be given a budget and general guidelines by Congress, but its recommended revised package could only be accepted or rejected by an up and down vote in Congress with that amendment.

In this way the oversight and broad policy role of Congress would be retained, but the Members of Congress would be able to avoid becoming embroiled in the frustrating task of trying to determine a detailed benefits package.

I have no doubt that the first proposed package from such a benefits board would include a realistic drug benefit.

Mr. Chairman, the FEHBP is a remarkably successful Federal health program.

It is successful because of the way that it is designed, and because of the way that OPM is permitted to run it. I would strongly urge Congress to look very carefully at the central features of the program as elements to include in the long term reform of Medicare. Thank you.

[The prepared statement of Stuart M. Butler follows:]

PREPARED STATEMENT OF STUART M. BUTLER, VICE PRESIDENT, DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION

My name is Stuart Butler. I am Vice President for Domestic and Economic Policy Studies at The Heritage Foundation. I must stress, however, that the views I ex-

press are entirely my own, and should not be construed as representing the position of The Heritage Foundation.

It is wise of the Committee to explore the applicability of the Federal Employees Health Benefits Program (FEHBP) as a model for reform of the Medicare program. The FEHBP, which is run by the Office of Personnel Management (OPM) is an interesting contrast to Medicare. Both are large health care programs run by the federal government. But there the similarity ends. The FEHBP is not experiencing the severe financial problems faced by Medicare, and nor are there complaints that it lacks important benefits, such as drug coverage. It is run by a very small bureaucracy, which, unlike Medicare's staff, does not try to set prices for doctors and hospitals. It offers choices of modern benefits and private plans to federal retirees (and active workers) that are unavailable in Medicare. It provides comprehensive information to enrollees. And it uses a completely different payment system, blending a formula and negotiations.

It is time for Congress to examine closely the system they are enrolled in themselves and incorporate key features of the program into Medicare.

HOW THE FEHBP WORKS

Created by Congress in 1959, the FEHBP offers about 200 competing private plans to active and retired Members of Congress and congressional staff, as well as active and retired federal and postal workers and their families—altogether almost 9 million people. Enrollees in any location have a choice of several plans, including national plans. The FEHBP population is by no means an ideal insurance pool. For one thing, the average age of the FEHBP population of active employees is rising, as is the proportion of higher-cost federal retirees in the program. In addition, plans may not impose "waiting periods" or limitations or exclusions from coverage for preexisting medical conditions, nor can they base premiums on medical risk.

Federal workers and retirees can choose from a variety of health plans, ranging from traditional fee for service plans to insurance plans sponsored by employee organizations or unions, to managed care plans. HMOs in FEHBP have benefits that are especially attractive to the elderly, including catastrophic coverage and mental health coverage. Almost all cover care in an "extended care facility," some with no dollar or day limits. And unlike Medicare, most FEHBP plans cover prescription drugs and include a wide range of dental services. Furthermore, the elderly can choose plans with specialized items, such as diabetic supplies.

How The Elderly Pick Plans. Each year, in preparation for the fall annual "Open Season," when retirees and regular employees pick plans for the following year, OPM sends beneficiaries an *FEHBP Guide,* which includes a standardized health plan comparison chart. There is also an excellent website that allows plan comparisons to be made. Health plans also provide retirees with information on benefits and premiums in a variety of ways, including advertising. Perhaps the most valued consumer resource for federal employees and retirees is *Checkbook's Guide to Health Insurance Plans for Federal Employees,* published by a consumer organization. The popular *Guide* compares plans, gives employees and retirees general advice on how to pick a plan, outlines plan features and special benefits, presents detailed cost tables (including the out-of-pocket limits for catastrophic coverage), and presents "customer satisfaction surveys" on the performance of plans. The *Guide* also provides specialized advice for federal retirees, including retirees with and without Medicare and information on HMO options and Medicare.The *Guide's* "customer satisfaction surveys" are quite detailed, rating plan performance in such areas as access to care, the quality of care, the availability of doctors, the willingness to provide customer information and advice by phone, the ease of getting appointments for treatments or check-ups, typical waiting times in the doctor's office, access to specialty care, and the follow-through on care. The surveys also review patient experience with such things as an explanation of care, the degree to which the patient is involved in decisions relating to care, the degree to which the plans' doctors take a "personal interest" in the patient's case, advice on prevention, the amount of time available with the doctor, the available choice of primary care physicians and access to specialists, and the speed with which the patient can contact the plan's service representative.

Beyond this valuable information, organizations representing enrollees also provide information. For example, federal retirees can receive additional guidance from the National Association of Retired Federal Employees (NARFE), a private organization representing approximately 500,000 current and retired federal employees. With a network of over 1,700 chapters throughout the country, NARFE works closely with the OPM in answering questions and resolving problems related to health insurance and retirement matters. In preparation for "Open Season," NARFE pub-

lishes its annual *Federal Health Benefits and Open Season Guide.* Most important of all, NARFE actually rates plans on benefit packages that would be most attractive to the elderly.

The Role of the Office of Personnel Management. OPM is given authority in the FEHBP statute to: contract with health insurance carriers; prescribe "reasonable minimal standards" for plans; prescribe regulations governing participation by federal employees, retirees and their dependents, as well as to approve or disapprove plan participation in the FEHBP; set government contribution rates in accordance with federal law; make available plan information for enrollees; and administer the FEHBP trust fund, the special fund containing contributions from the government and enrollees and from which all payments to health plans are made.

Unlike Medicare, OPM does not impose price controls or fee schedules, or issue detailed guidelines to doctors or hospitals or standardize benefits. By law, private plans within the FEHBP must meet "reasonable minimal" standards regarding benefits. But the law creating FEHBP does not specify a comprehensive set of standardized benefits. Congress merely defines the "categories" or "types" of benefits that are to be provided; the level or duration of medical treatments or procedures is largely left to negotiation and the choice of enrollees in a dynamic market.

The Premium Negotiation Process. OPM sends out a "call letter" in the Spring of each year to insurance carriers, inviting them to discuss rates and benefits for the following calendar year. In these confidential discussions, OPM outlines its expectations on rates and benefits to the carriers, and the carriers invariably respond by offering proposals for packages and premiums. Government managers negotiate premiums before they are posted for the open season. This is a largely successful mixture of discussion and jawboning.

For HMO and point of service (POS) plans, OPM typically starts its negotiations based on the local market for these plans—it does not, as in the case of Medicare, apply a formula based on the local fee-for service market. In the case of fee-for-service and preferred provider organization (PPO) plans, OPM negotiates a fixed profit per subscriber. Thus the plans make money through negotiated service contracts rather than traditional profits. While these plans must accept market risk, they must lodge revenue surpluses in special reserve accounts.

To some extent this negotiation system means the government exercises "price maker" power. But the plans still must design and price their product shrewdly in strong competition with each other for enrollees if they are to remain in business. Significantly, OPM devotes most of its negotiating energy with the large plans that determine the government's maximum contribution, and largely ignores the pricing of other plans. It is not clear that the government's jawboning function in the FEHBP is as important in holding down costs than this competition for price-sensitive enrollees. But what is clear is that OPM bargaining with competing plans is far more successful at holding down costs than CMS issuing edicts to hospitals and physicians.

Other OPM Functions. In setting the government contribution to retirees health benefits, OPM make its calculations according to a formula established by law, under which OPM pays a percentage of the premium chosen by the enrollee up to a **maximum** dollar amount linked to the costs of certain comprehensive plans. Whatever the plan chosen, the government's premium is sent directly to the plan. The enrollee's premium contribution normally is deducted from the enrollee's paycheck (for workers) or annuity (for retirees) and also sent by OPM directly to the chosen plan. OPM also helps retirees and employees settle disputed claims.

OPM prepares kits outlining rates and benefits for the coming calendar year, disseminating information on the plans. Beneficiaries then pick a plan during open season. OPM maintains an "Open Season Task Force" to help in making decisions, and a hot line that retirees (or regular workers) can call during open season.

APPLYING FEHBP'S STRUCTURE TO THE MEDICARE PROGRAM

Congress could introduce key features of the successful FEHBP program into Medicare by taking several important steps.

1) Remove from CMS the function of managing a competitive market of managed care plans and the traditional fee-for-service program and instead place this function under a new Medicare Board with powers to negotiate prices and services with plans.

CMS currently is responsible for operating the traditional fee-for-service program. But is also responsible for establishing and managing the market for managed care plans that compete directly with its fee-for-service program. This mixed role or umpire and competitor conflicts with a basic principle of economic organization in a market—those responsible for setting the rules of competition, and providing con-

sumers with information on rival products, should have neither an interest in promoting any particular product nor even a close relationship with one of the competitors. That is why the Securities and Exchange Commission maintains a wall of separation between itself and individual companies. It is why Consumers' Reports accepts no advertising from products it evaluates. Entangling the running of a market with the management of any of the competing providers is a recipe for problems. Significantly, OPM does not run a plan itself.

This separation is not only necessary to avoid a conflict of interest, it is also necessary because the managerial cultures are very different for staff engaged in these two very different functions. Managers charged with dispassionately operating a market must display evenhandedness and pay close attention to the information that consumers need to make wise decisions. On the other hand, those managers engaged in marketing a particular plan, including a government-sponsored plan, must be highly competitive and concerned with the long-term viability of their particular product and the continued satisfaction of their customers. The cultural difference is much like that separating a judge from a trial attorney.

The Breaux-Thomas Medicare Commission recognized this inherent conflict when a majority of members voted to establish a board to take over many of the marketing functions, and the management of private plans, now undertaken by CMS. To establish such a Board, Congress should create within the Medicare program a body that is the functional equivalent of the Office of Personal Management within the FEHBP. The function of this body, and the focus of the staff within it, should be to structure and operate a market of competing plans, including the traditional fee-for-service plan, and to provide Medicare beneficiaries with the information they need to make the wisest choice possible.

The new Board should answer directly to the Secretary of the HHS, and would have similar functions to those of OPM within the FEHBP. It would take over many of the Medicare functions currently assigned to CMS, leaving CMS's Medicare staff to focus on the administration of the fee-for-service Medicare program. Among the Board's functions:

- *Setting standards for all plans being offered to Medicare beneficiaries, and certifying that all plans meet those standards.* The Board should be responsible for setting the "ground rules" for inclusion in Medicare, including solvency requirements and information requirements. The standard setting should apply to the traditional fee-for-service program as well as the new choice programs created by Congress.
- *Negotiating with competing plans regarding benefits and prices.* Just as OPM negotiates with individual plans before they are offered to federal employees during open season, so the Board should be given latitude by Congress to negotiate premiums with managed care plans. This would be a marked improvement on the current formulas established by Congress, which lead to payment levels that are out of line with local markets. Under a system of premium/payment negotiation the Board would be able to balance the government's cost and the availability of plans in an area, something it is hampered from doing today.
- *Organizing payments to chosen plans.* The Medicare Board would be responsible for the payments to plans.
- *Providing data and information to consumers.* The Board would take on the function of providing consumer and benefits information to seniors and guidance on how to make wise choices. This function would include examining techniques to measure quality and incorporating prudent techniques into the information made available to beneficiaries.

In order to carry out its mission effectively, the Board itself should contain certain elements. One of these should be an Advisory Council, mainly representing consumers but also organizations with a general interest in creating a market for high quality health care. However, the Board, and the Advisory Council, should receive policy and technical advice on issues affecting the market for Medicare plans from an outside advisory body with experience of other health care markets. I would suggest the Medicare Payment Advisory Commission (MedPAC), with an expanded staff, could play this role.

In addition, the Board would need a full staff to undertake its broad functions. Some of these staff could be recruited from current CMS personnel. But it would be wise to recruit some staff from outside HHS in order to introduce new skills and experience. Some individuals might be recruited from OPM, and others from the private sector.

2) To enable the basic benefits package to be revised and improved steadily over time, the current politicized process for changing benefits should be replaced with a Benefits Board and other steps.

The current discussion about the need to add an outpatient drug benefit to Medicare simply underscores two related failings in the design of the program. The first is that ever since its inception, the Medicare benefits package has slipped further and further behind what would be acceptable in typical plans for the working population. The second is that the program will be constantly out of date as long as it takes an act of Congress to accomplish benefits changes in Medicare that in the private sector would be made in a few routine management meetings.

The main reason that the benefits package is out-of-date despite general acceptance it needs to include such items as a drug benefit is that all major changes in benefits require an act of Congress. Consequently, discussions about changing benefits are necessarily entangled in the political process. Providers included fight hard and usually effectively to block hard attempts to scale back outdated coverage for their specialty. Meanwhile, talk of upgrading the Medicare benefits package unleashes an intense lobbying battle among other specialties seeking to be included in Medicare benefits. Invariably, the final result depends more on shrewd lobbying and political polling than on good medical practice.

A long-term reform of Medicare must end the structurally inefficient and politicized system of changing or modifying benefits over time. The best way to do this involves three steps:

- **Set only broad benefit categories in Congress.** Rather than set detailed benefits in legislation, Congress should confine itself to describing the broad categories of benefits that private plans competing in Medicare should provide (such as emergency care, drug benefits, etc.). This is the approach Congress has taken with the FEHBP program. In addition, Congress could establish the minimum "bare bones" benefits each plan must have—leaving the Medicare Board to negotiate additional benefits plan-by-plan.
- **Create a Medicare Benefits Board.** Instead of Congress or the Administration specifying detailed benefits for the fee-for-service program (or the minimum benefits for managed care plans), Congress should create a Benefits Board to propose specific incremental changes in these core benefits. Such an independent board would have members selected for specific terms by the Administration and Congress. The package recommended by the Benefits Board would then be subject to an up or down vote by Congress. This would reduce political pressures on benefit decisions and take lawmakers out of the process of making detailed medical decisions, and yet it would give Congress the final say in any benefits changes. Essentially the practical logic for establishing a board to function in this way is the same as the logic for creating the Base Closing Commission in the 1980s.

  The first task for the proposed Benefits Board should be to determine the best way to introduce a drug benefit into the traditional fee-for-service segment of Medicare. With a Board in place, Congress could instruct it to develop a modified benefits package, including drug coverage, within a specified budget. To work within the budget constraints, the Board might develop a plan to make small changes in a number of features of the benefits package to achieve a well-balanced package that achieved Congress' objectives. The plan would be sent to Congress for an up-or-down vote without amendment. Should it fail to win approval, the Board would develop a modified version until agreement could be reached.

3. Empower the traditional fee-for-service program to compete.

Because of the statutory basis of the fee-for-service benefits package, and the many requirements Congress places on CMS, it is currently very difficult for the agency to make sensible improvements in the fee-for-service program to more it competitive and modern.

The Breaux-Thomas Medicare Commission discussed giving CMS more flexibility to enable the fee-for-service program to compete more effectively. This makes sense—though, for the reasons discuses earlier, only if the agency is relieved of the power to set the rules for competition.

Congress should address this inflexibility by giving CMS the same ability to compete as states and local governments routinely give "in-house" public agencies when they are subject to competitive bids from the private sector. There is no reason why public enterprises cannot be competitive and entrepreneurial. In virtually every state of the union we see such innovation, from the delivery of municipal services to public education.

More specifically, Congress should give CMS greater flexibility to run the traditional fee-for-service program in ways that would make it an aggressive competitor to managed care plans and other emerging private sector health care options in the next century. Whenever a competitive market is introduced, the government-provided service must be given every opportunity to redesign itself to compete effectively. This should be so in Medicare. Thus CMS should be granted greater discretion to introduce innovations into the management of traditional fee-for-service Medicare. It should be allowed, for instance, to make extensive use preferred provider organizations of those physicians and hospitals giving the best value for money. It should also be allowed to further contract out the management of the traditional program in areas where that might improve Medicare.

4) **Amend the plan payment system to make it more like that used in the FEHBP.**

A form of "premium support" financing much like that in the FEHBP is the best way to achieve the goals of a high-quality Medicare system that is affordable to taxpayers as well as seniors. Under an FEHBP-style payment system, Medicare beneficiaries would receive a percentage contribution to the cost of their chosen plan, up to a maximum dollar amount. But this mechanism can be adjusted so that the elderly and disabled are not at risk for long term changes in the cost of their health coverage. In fact, a premium support arrangement can be modified in several ways to address variety of policy goals and to protect enrollees. For example:

- **The maximum contribution could be adjusted each year**—or indexed—to cover the market price of major plans providing comprehensive benefits. In that way the elderly would continue to have an entitlement and know that the costs of comprehensive coverage would be assured, but the premium support approach means they would also have a strong incentive to choose a cost effective plan.
- **A minimum amount of premium support could be established** and this could be adjusted by income, so the low-income senior would have a larger amount of financial assistance for any given plan.
- The minimum and maximum amount could be **adjusted (i.e. indexed) to account for the higher costs of certain medical conditions** warranting more elaborate coverage.

Mr. NORWOOD. Thank you, Mr. Butler.

Mr. Richtman, you are now recognized.

STATEMENT OF MAX RICHTMAN

Mr. RICHTMAN. Good morning, Mr. Chairman, and ranking member Brown, and members of the subcommittee. Thank you for holding this important hearing on the issue of Medicare modernization and for inviting me to speak this morning.

I am the Executive Vice President of the National Committee to Preserve Social Security and Medicare, a seniors, grass-roots, education and advocacy organization, with millions of members and supporters around the country.

We are extremely concerned that any Medicare modernization ensures seniors continued access to a defined benefits package, reasonable premiums, and out-of-pocket-expenses, and access to the physician of their choice.

Cost to the beneficiary is one of our main concerns. While Medicare has made significant advances over the past 35 years in improving the health and lives of seniors, seniors still pay a significant portion of their health costs out-of-pocket, in part because they use more services as a result of their health care needs and in part because Medicare does not cover many important preventive benefits, including prescription drugs.

Seniors have been asking policymakers to determine ways to reduce their burdensome out-of-pocket expenses. We must ensure

that the costs to beneficiaries does not escalate as a result of any Medicare modernization plan.

The most important and critical improvement needed in the Medicare program is to provide a prescription drug benefit. The typical senior fills 18 prescriptions a year, and at an average cost of $1,650.

Yet, one-third of beneficiaries have no prescription drug coverage at all. With regard to choice, and this has been mentioned a number of times this morning, seniors do want options and choice, but they want a choice of physicians and not of plans.

Seniors need a defined benefit package they can count on. It is not clear that in the FEHBP and in premium support models that there will be a defined benefit.

Seniors need predictable benefits that don't decrease over time and costs that don't drastically increase for basically the same benefits, nor vary from region to region.

Benefits should remain portable so that the senior moving from one State to another State will have the same benefits. We have serious concerns about applying the FEHBP model to Medicare, because the age of the current population is so different.

The average Federal employee is 45 years old. Most on Medicare are at least 65. Naturally the health care costs for seniors will be much higher. On the issue of cost, premiums in FEHBP have increased steadily over the last 5 years.

How can this be a model for cost savings for Medicare, particular because we know that seniors' medical costs are much higher as I just mentioned.

Medicare must continue to be we feel a social insurance program with a traditional fee for service plan that is available to everyone who needs it. Seniors often fear private insurance companies because they have seen how Medicare+Choice Plans have treated them.

Many seniors have been adversely affected when the plans they have enrolled in elect to withdraw from their communities, decrease benefits, or increase premiums and co-pays.

Seniors need and deserve stability, dependability, and affordability. Mr. Chairman, and members of the subcommittee, we ask that you consider the cost to seniors as you deliberate Medicare modernization.

On behalf of millions of our national committee members and supporters around the country, and seniors across the Nation, we request that you ensure all current and future Medicare beneficiaries that have access to a reliable, predictable, affordable, defined benefit, fee-for-service program. Thank you very much.

[The prepared statement of Max Richtman follows:]

PREPARED STATEMENT OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Good Morning Chairman Bilirakis, Ranking member Brown and members of the committee. Thank you for holding this important hearing on the issue of Medicare Modernization and for inviting me to speak. I am executive vice president of the National Committee to Preserve Social Security and Medicare, a senior's grass root's education and advocacy organization with millions of members and supporters.

We are extremely concerned that any Medicare modernization ensures seniors continued access to a defined benefit package, reasonable premiums and out of pocket expenses, and access to the physician of their choice. Cost to the beneficiary is

one of our main concerns. While Medicare has made significant advances over the past 35 years in improving the health and lives of seniors, seniors still pay a significant portion of their health costs out of pocket, in part because they use more services as a result of their health care needs and in part because Medicare does not cover many important preventive treatments including prescription drugs. Seniors have been asking policymakers to determine ways to reduce their burdensome out-of-pocket expenses. Therefore, we must ensure that the cost to beneficiaries do not escalate as a result of any Medicare modernization plan.

The most important and critical improvement needed in the Medicare program is to provide a prescription drug benefit. The typical senior fills 18 prescriptions per year at an average cost of $1,650. Yet, one third of beneficiaries have no prescription drug coverage.

With regard to health care providers, seniors do want options and choice. However, they report wanting a choice of physicians, not a choice of plans. Seniors need a defined benefit package they can count on. It is not clear than in FEHBP and in premium support models there will be a defined benefit. Seniors need predictable benefits that don't decrease over time and costs that don't drastically increase for the same benefits, nor vary from region to region. Benefits should remain portable so that the senior moving from state to state will have the same benefits.

We have serious concerns about applying the FEHBP model to Medicare because the age of the covered population is so different. The average federal employee is 45; most on Medicare are at least 65. Naturally, the health care costs for seniors will be much much higher.

On the issue of cost, premiums in FEHBP have increased steadily over the last 5 years. How can this be a model for cost savings for Medicare? Particularly, because we know seniors' medical costs are much higher.

Medicare must continue to be a social insurance program with a traditional fee for service plan that is available to everyone who needs it. Seniors often fear private insurance companies because they see how Medicare Plus Choice plans have treated seniors. Unfortunately, many seniors have been adversely affected when the plans they have enrolled in elect to withdraw from their communities, decrease benefits and/or increase premiums and copays. Seniors need stability, dependability and affordability.

In FEHBP, all plans are on an equal playing field; this is not a good model for Medicare. Fee for service cannot be on an equal playing field with private insurance plans. The oldest, sickest, poorest, most costly seniors will have to remain in fee for service. This will drive up the cost of the fee for service program. However, the oldest, sickest, poorest seniors should not pay more in cost sharing. This is the principle of social insurance. Fee for service must be protected and guaranteed.

Mr. Chairman and members of the committee we ask that you consider the cost to seniors as you deliberate on any Medicare modernizations. On behalf of our millions of National Committee members and seniors across the nation, we request that you ensure all current and future Medicare beneficiaries have access to a reliable, predictable and affordable defined benefit traditional fee for service program.

Thank you.

Mr. NORWOOD. Is it deMontmollin?

Mr. DEMONTMOLLIN. Yes, sir.

Mr. NORWOOD. Mr. deMontmollin, you are now recognized.

STATEMENT OF STEPHEN J. deMONTMOLLIN

Mr. DEMONTMOLLIN. Mr. Chairman, Ranking Member Brown, and members of the subcommittee, my name is Steve deMontmollin, and I am the Senior Vice President and General Counsel of AvMed Health Plan, Florida's oldest and largest not-for-profit HMO, representing nearly 30,000 Medicare beneficiaries, 20,000 Medicaid, and 15,000 Federal employees, and tens of thousands of well satisfied Medicaid, FEHBP, State employees, and other commercial members, who have benefited by the leadership of Chairman Bilirakis, I can assure you, in the areas of southwest Florida.

I am also testifying on behalf of the American Association of Health Plans, which represents more than 1,000 health plans serv-

ing 170 million Americans, and its membership includes most Medicare+Choice organizations.

I appreciate the opportunity to testify regarding Medicare reform and the urgent need to act on short term measures to stabilize the Medicare+Choice program as longer term reform strategies are developed and implemented.

Mr. Chairman, unless immediate action is taken to address the funding crisis confronting Medicare+Choice, we will lose the foundation of private plans needed to help fulfill long term goals related to providing seniors more choices in a reformed Medicare program.

AAHP members will support Medicare reform proposals based on the following principles. First, Medicare reform must expand choices for beneficiaries. Second, Congress should include all aspects of Medicare in any reform proposal.

It is particularly important that Congress create a level playing field between Medicare+Choice and fee-for-service Medicare. Next, reform should permit flexibility and benefit design, while requiring all plans to offer a core set of benefits.

Government payment must be sufficient to allow individuals to have a reasonable level of choice among plans, and to ensure that choices remain available over time. Finally, a fair balance must be found between the need for regulatory oversight and the promotion of quality health care for all Medicare beneficiaries.

If Congress examines options for reforming Medicare, it is important to consider competitive models similarly to that used by the Federal Employees Health Benefits Program. For example, FEHBP establishes a level playing field for all coverage options.

Both managed care plans and fee-for-service plans are governed by the same regulatory structure, and are paid under the same payment structure. This approach contrasts sharply with the competitive bidding demonstration projects that were pursued unsuccessfully under the previous administration.

Health plans also believe that an affordable prescription drug benefit should be a part of a reform Medicare program. This benefit should be flexible and financially sustainable.

As you know, many Medicare+Choice plans have been providing prescription drug coverage, serving as a critical source of prescription drugs for low income beneficiaries.

Plans are well positioned to help Congress make drug coverage available to beneficiaries while containing rising drug costs. While we are pleased that health plans are featured prominently in visions of Medicare reform, absent funding relief, however, business realities will force more plans to leave the program, and by the time that longer term reforms are enacted, policymakers may find that the infrastructure that they were counting on no longer exists.

But for the wisdom of Chairman Bilirakis and this subcommittee in establishing the minimum floor rate, the current infrastructure may not be in place as it is today.

In addition to its importance for reform, Medicare+Choice is a valuable option for beneficiaries. Medicare+Choice plans provide high quality, affordable health care coverage, emphasizing coordinated care and preventive services.

Studies show that Medicare+Choice plans do a better job of delivering services to the chronically ill and serve as a crucial safety net

for many low income beneficiaries. In the context of the Medicare+Choice Program, I have a few basic points that I would like to raise.

First, Medicare+Choice payments are not keeping up with rising health care costs. Compounding that problem, health plans are not receiving funds that Congress targeted to the Medicare+Choice program.

Most of the flow through funds that the Congressional budget office expected to reach Medicare+Choice through the BBA adjustment packages did not materialize because of the blend component of the Medicare+Choice payment methodology was not implemented.

Over the next 3 months, health plans must decide whether they will participate in the Medicare+Choice program in 2003. If Congress does not act soon, those decisions will be based on current program realities.

And in that event, members should expect that additional beneficiaries will lose the health plan choices they value. No one wants that to happen. To that end, AAHP and its members stand ready to assist in addressing the serious problems in the Medicare+Choice program.

Thank you for this opportunity to testify and I look forward to answering your questions.

[The prepared statement of Stephen J. deMontmollin follows:]

PREPARED STATEMENT OF STEPHEN J. DEMONTMOLLIN, VICE PRESIDENT AND GENERAL COUNSEL, AVMED HEALTH PLAN ON BEHALF OF AMERICAN ASSOCIATION OF HEALTH PLANS

I. INTRODUCTION

Chairman Bilirakis and members of the subcommittee, my name is Stephen J. deMontmollin. I am Vice President and General Counsel of AvMed Health Plan. Based in Gainesville, Florida, AvMed is Florida's oldest and largest not-for-profit HMO, serving some 300,000 members, including approximately 30,000 Medicare members and 10,000 federal employees and their dependents. AvMed contracts with close to 7,000 physicians and 126 hospitals, is federally qualified and is accredited by both the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

AvMed appreciates the opportunity to testify regarding Medicare reform and the urgent need to act on short-term measures to stabilize the Medicare+Choice program as longer-term reform strategies are developed and implemented. Our company is committed to making high quality health insurance coverage available to the people of Florida. It is our hope that your Committee will act early in the year to make the changes needed to Medicare+Choice to allow us to sustain and expand our commitment to Florida's Medicare beneficiaries.

I am also testifying today on behalf of the American Association of Health Plans, of which AvMed is a member. AAHP and its member plans have a longstanding commitment to Medicare and to the mission of providing high quality, affordable, patient-centered health coverage to beneficiaries. AAHP represents more than 1,000 HMOs, PPOs, and similar network health plans, and its membership includes most Medicare+Choice organizations. Together, AAHP member plans provide coverage for more than 170 million Americans nationwide.

My testimony addresses three components of the Medicare reform debate. First, I will set forth basic framing principles for consideration in any debate over comprehensive reform of the underlying Medicare program. Next, I will talk about some of the policy issues that should be considered in the context of adding a new outpatient prescription drug benefit to Medicare. Finally, I will identify the immediate changes that must be made to stabilize Medicare+Choice in order to ensure that it will continue to exist by the time comprehensive reform and a new drug benefit are implemented. I cannot emphasize strongly enough that unless immediate action is taken to address the funding crisis confronting Medicare+Choice, the foundation of

private plans needed to help fulfill long term goals related to providing seniors more choices in a reformed Medicare program will not exist, and Medicare beneficiaries' access to quality health care choices will be denied.

II. COMPREHENSIVE MEDICARE REFORM

I commend the Committee for its continuing work to protect and preserve the Medicare program for future generations. AAHP and its members look forward to working with the Committee to develop competitive approaches to Medicare reform, based on a level playing field for all Medicare options, to ensure that the program remains a reliable source of high quality health care in the years to come. We are committed to participating constructively to advance Medicare reform proposals based on the following principles:

- **Expand Choices for Beneficiaries:** Ensuring a strong Medicare program requires offering beneficiaries an expanded range of options. Consumers in the private sector have benefited from the widespread availability of health plan options, which has promoted access to affordable, comprehensive coverage. Congress endorsed the principle of expanded choice in creating the Medicare+Choice program in the Balanced Budget Act of 1997 (BBA). Medicare+Choice was designed to include not only health maintenance organizations and point-of-service plans that participated under the Medicare risk program, but also provider-sponsored organizations, preferred provider networks, and private fee-for-service plans.

  Expanded choice will be rendered meaningless, however, unless these choices are available in the market and affordable to beneficiaries. Any Medicare reform proposal, including proposals based on competitive bidding models, should seek to ensure that the coverage options from which beneficiaries can choose include some options that cost beneficiaries no more than options available under the current Medicare program.
- **Include All Aspects of Medicare in Reform Proposal:** Although millions of beneficiaries have chosen to enroll in a Medicare+Choice plan, the overwhelming majority of Medicare beneficiaries remain in the fee-for-service program. No serious reform proposal can proceed without tackling the problems confronting fee-for-service as well as Medicare+Choice, and as fundamental Medicare reforms are enacted, it is particularly important that Congress create equivalent rules for all Medicare options. This will allow beneficiaries broad choice within a consistent set of performance standards.
- **Promote Greater Choice For Beneficiaries By Permitting Flexibility in Benefit Design:** All options should offer a core set of benefits. Generally health plans offer beneficiaries a choice of additional benefits, such as prescription drugs and lower cost sharing in exchange for a selective provider panel. Any Medicare reform proposal should recognize that granting plans benefit flexibility enables them to design additional benefits and to structure cost-sharing requirements in a manner that maximizes beneficiaries' coverage choices and that allows plans to provide benefits that coincide with the level of government payment. Adequate payment for the core set of benefits is fundamental, without which health plans cannot offer the supplemental benefits valued by enrollees.
- **Provide a Government Contribution that Adequately Funds Choice:** Determining the amount of the government contribution will be a critical decision in the design of any Medicare reform proposal. This amount should be sufficient to allow individuals to have a reasonable level of choice among plans within an area and to ensure that choices remain available and stable over time. Additionally, the contribution amount should preserve choices available in currently successful markets and support expansion of choices in the rest of the country.
- **Develop an Improved Regulatory Framework:** Health plans and other options participating in a reformed Medicare program should be administered under a new framework designed to achieve a fair and sound balance between the need for regulatory oversight and the promotion of quality health care for all Medicare beneficiaries. The new framework should seek to minimize the potentially conflicting objectives evident under the Centers for Medicare and Medicaid Service's (CMS) current roles as a purchaser, regulator, and competitor.

FEHBP Model Offers Useful Lessons

As Congress examines options for reforming Medicare, it is important to consider competitive models similar to that used by the Federal Employees Health Benefits Program (FEHBP).

A competitive system modeled after FEHBP would have characteristics that offer considerable potential for expanding beneficiary choices and encouraging private

health plan participation in the Medicare program. While the FEHBP model would have to be modified in a number of areas before it could be applied to the Medicare program, this approach has many worthwhile features. For example, FEHBP establishes a level playing field for all coverage options—both managed care plans and fee-for-service plans are governed by the same regulatory structure and paid under the same payment structure. This approach contrasts sharply with the competitive bidding demonstration projects that were pursued unsuccessfully under the previous Administration.

If adequately funded and sensibly regulated, a Medicare program based on competition could prove to be an effective approach to meeting the health care needs of Medicare beneficiaries. Still, it is important for Congress to recognize that the beneficiary populations served by Medicare and FEHBP are very different and that it would not be appropriate to simply impose the FEHBP model on the Medicare program without modifications to fit the senior and disabled population.

III. PRESCRIPTION DRUG COVERAGE

As the Energy and Commerce Committee continues to tackle the range of difficult issues associated with Medicare reform, health plans continue to believe that creating an affordable prescription drug benefit under Medicare should be a primary goal. In establishing the Medicare program thirty-six years ago, our nation made a commitment not only to the elderly and disabled who directly benefit from the program, but also to their families whom otherwise would bear the overwhelming costs of their health care. As more prescription drugs have become available and have taken a more critical role in medical treatment, especially to the chronically ill, the absence of an outpatient prescription drug benefit in the Medicare program has become problematic for many Medicare beneficiaries and their families.

AAHP and its member plans strongly support making a well-designed, flexible and financially sustainable drug benefit available to Medicare beneficiaries.

- **Many Medicare+Choice plans have been providing prescription drug coverage.** Health plans have been a primary source of coverage for vulnerable beneficiaries. For several years now, Medicare+Choice plans and their predecessors, Medicare risk plans, have been a critical source of prescription drug coverage for many seniors and the disabled. A majority of Medicare beneficiaries without drug coverage paid for by Medicaid or by a former employer choose our plans as their source of prescription drug coverage. Furthermore, Medicare+Choice enrollees have expressed consistently high levels of satisfaction with their plans[1]. AAHP members stand ready to offer their knowledge and experience as Congress considers ways to provide a prescription drug benefit for senior citizens. Because Medicare+Choice plans completely integrate outpatient pharmaceutical coverage into the Medicare coverage they offer, Medicare+Choice plans are—and continue to be—well positioned to offer beneficiaries an effective coverage option.
- **Medicare+Choice is a Critical Source of Prescription Drugs for Low-Income Beneficiaries without Subsidized Supplemental Coverage.** While Medicaid provides coverage for the lowest income beneficiaries and other beneficiaries may have supplemental insurance subsidized by a former employer, supplementing Medicare for drugs and other treatments can be prohibitively expensive, particularly for those on fixed incomes. An AAHP analysis of HCFA data from 1997 demonstrated that Medicare plans serve many financially vulnerable beneficiaries, principally those without subsidized supplemental coverage and those with limited or modest incomes who are not eligible for Medicaid.[2] A recent Health Affairs study confirms this.[3]
- **Medicare+Choice organizations can help Congress make drug coverage available to beneficiaries while helping control rising drug costs.** Members of Congress face two competing policy objectives: making a comprehensive prescription drug benefit available to Medicare beneficiaries while simultaneously controlling the program's escalating costs. Health plans are well positioned to help Congress achieve its policy goals.

  Medicare+Choice organizations use advanced pharmacy management techniques integrated with medical and surgical benefits. It is important to recog-

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[1] Medicare risk and Medicare+Choice enrollees have consistently expressed overall satisfaction with their quality of care at percentage rates in the mid-to-high nineties. See MedPAC Reports to Congress dated March 2000 (p. 34) and June 1998 (p. 133).

[2] AAHP, "Financially Vulnerable Medicare Beneficiaries Rely on HMOs for Prescription Drug Coverage," May 2000.

[3] Laschober, MA et al. Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999. Health Affairs Web Exclusive, February 27, 2002.

nize, however, that even with the use of state-of-the-art pharmacy management tools pioneered by private health plans, prescription drug expenditures are escalating rapidly. To function properly in this environment, any prescription drug benefit must be backed by adequate funding that is sustained over time. Moreover, any new prescription drug program should be designed to allow for the continued evolution of pharmacy management strategies that promote affordability and accessibility of prescription drugs. A new drug benefit should permit formulary management, generic substitution, and integrated retail and mail service for drug delivery. Lastly, any new regulatory framework that accompanies a prescription drug benefit should pave the way for the successful implementation of the program and its evolution as the program matures.

IV. STABILIZING MEDICARE+CHOICE

Health plans feature prominently in the longer-term visions of comprehensive Medicare reform and a new outpatient prescription drug benefit articulated by this and previous Administrations and by Members of Congress. However, steps must be taken immediately to ensure that private plans are able to continue to participate in the Medicare program. If the current cycle of underpayment is not halted, health plans will continue to wrestle each year with the difficult decision of whether it is possible to continue to remain in the Medicare+Choice program. Although the historical pattern of administrative inflexibility in Medicare+Choice is improving, additional changes are needed. Absent funding relief, business realities will force more and more plans to leave the program, and by the time longer-term reforms are ready to be enacted, policymakers may find that the infrastructure they were counting on no longer exists.

Health plans applaud President Bush for recommending a 6.5% payment increase for health plans that have been receiving the minimum payment update as a good first step. We call upon Congress to act quickly this year to build on the President's proposal to ensure that Medicare beneficiaries continue to be able to access the choices they value.

In the context of the Medicare+Choice program, I have six basic points I would like to raise.

- **Prior to 1997, Health Plan Choices for Medicare Beneficiaries Were Expanding.** Under the Medicare risk contract program that preceded Medicare+Choice, beneficiaries responded favorably to the high quality, affordable, and comprehensive health coverage offered by Medicare HMOs. Between 1993 and 1997, enrollment in Medicare HMOs increased at an average annual rate of 30 percent, reaching a level of 5.2 million by 1997.
- **The Balanced Budget Act Has Had Unintended Consequences.** While the Balanced Budget Act of 1997 (BBA) clearly achieved its objective of limiting spending throughout the entire Medicare program, this accomplishment has been achieved at the expense of another important objective—expanding health care choices for Medicare beneficiaries. In many areas where large numbers of beneficiaries have chosen Medicare+Choice options, health plans are absorbing cost increases of 10 to 13 percent annually and, at the same time, receiving payments that are increasing by only two percent annually (and three percent in 2001). The unintended consequences of the BBA have diminished health care choices for Medicare beneficiaries, as many health plans have been forced to withdraw from the program due to inadequate funding and excessive regulatory burdens.
- **Medicare+Choice Is a Valuable Option for Beneficiaries.** Medicare+Choice plans provide high quality, comprehensive, affordable health coverage—with a strong emphasis on coordinated care and preventive health care services—that is not available in the Medicare fee-for-service program. Research studies show that Medicare+Choice plans do a better job of delivering services to the chronically ill and serve as a crucial safety net for many low-income beneficiaries.
- **Medicare+Choice Funding is Inadequate.** Most of the "flow-through" or "indirect" funds that the Congressional Budget Office (CBO) attributed to the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA) did not reach the Medicare+Choice program in either 2001 or 2002. This is because the "blend" component of the Medicare+Choice payment methodology was not implemented in these years. As a result, Medicare+Choice plans will receive only $2.3 billion in reimbursement from BBRA and BIPA in the three-year period of 2000-2002, rather than the $5.8 billion that was scored by CBO. This amount represents only 12 percent of the $19.2 billion in estimated cuts from Medicare+Choice due to the BBA in this same three-year period.

- **The Medicare+Choice Program Has Been Hampered Since Its Early Years by Administrative Burdens.** CMS often has failed to consider whether the costs of regulatory requirements outweigh their benefits and, at the same time, forced health plans to spend scarce resources on compliance activities of sometimes questionable value—leaving plans with fewer resources to spend on patient care. Instead of setting priorities for ensuring beneficiary rights and plan accountability, the agency has created an inflexible regulatory environment that places equal—but arbitrary—emphasis on every requirement. Plans applaud recent CMS efforts to control the growth of the regulatory burden, but the volume of regulation is nevertheless overwhelming.
- **Action Is Urgently Needed to Protect Health Care Choices for Medicare Beneficiaries.** Efforts to stabilize the Medicare+Choice program should focus on: (1) providing adequate funding; (2) correcting flaws in the program's risk adjustment process; (3) repealing the Medicare+Choice enrollment "lock-in" requirement; and (4) continuing improvement in the regulatory environment.

Medicare Managed Care Was Highly Successful Prior to 1997

In 1982, Congress enacted new rules under which HMOs could serve Medicare beneficiaries through a Medicare risk contract program. Under this program, HMOs provided beneficiaries with a growing number of highly popular health care choices. Much like the Medicare+Choice plans of today, the Medicare HMOs that emerged in the mid-1980s offered a different approach to health care than beneficiaries experienced under the Medicare fee-for-service program. Medicare beneficiaries responded favorably to the high quality, affordable, and comprehensive health coverage offered by Medicare HMOs. Enrollment in Medicare HMOs reached one million by 1987, 1.8 million by 1993, and 5.2 million by 1997.

While the Medicare risk contract program created valuable health care choices for many beneficiaries, in many areas of the country beneficiaries did not have access to Medicare HMOs largely because of variations in the program's payment rates. Under the Medicare risk contract program, HMOs were paid a set amount for each beneficiary based on 95 percent of the average per capita costs of providing covered services in the Medicare fee-for-service program in the beneficiary's county of residence. Because there are wide geographic variations in fee-for-service payments, there were also wide geographic variations in Medicare HMO payments. In addition, the willingness of health care providers to contract with health plans varied significantly across geographic areas—just as it does today. As a result of these factors, Medicare HMOs were plentiful in some areas, but unavailable in others. Concerns about this issue, combined with other factors, led to major legislative developments in 1997.

The Balanced Budget Act of 1997 Has Had Unintended Consequences

The Balanced Budget Act of 1997 (BBA) repealed the Medicare risk contract program and replaced it with a new Medicare+Choice program. One of the BBA's stated goals was to provide the benefits of the Medicare risk contract program to beneficiaries in more areas of the country. In addition, the BBA placed a strong emphasis on strictly limiting future Medicare spending, for both managed care coverage and fee-for-service coverage, as part of a broader effort to balance the federal government's budget.

At the time the BBA was enacted, the Congressional Budget Office (CBO) estimated that the BBA's Medicare+Choice provisions would achieve $22.5 billion in budget savings over five years (1998-2002). Moreover, the Clinton Administration announced in January 1999 that it intended to cut Medicare+Choice funding by an additional $11.2 billion over five years (2000-2004) through the approach it had chosen for implementing a new risk adjuster. The Bush Administration has since signaled that it will take a different approach to implementing the risk adjuster. Even if the Bush Administration chooses to implement a budget neutral risk adjuster, significant savings has already been squeezed from the Medicare+Choice program during the transition from the Medicare risk contract program.

While the BBA clearly achieved its objective of limiting spending throughout the entire Medicare program, this accomplishment has been achieved at the expense of another important objective—expanding health care choices for Medicare beneficiaries. The unintended consequences of the BBA have diminished health care choices for Medicare beneficiaries as many health plans have been forced to withdraw from the program due to inadequate funding and excessive regulatory burdens.

Following the enactment of the BBA, Medicare beneficiaries paid a heavy price as two major problems—underfunding and over-regulation—forced many health plans to either withdraw from the Medicare+Choice program or reduce their service

areas. As a result, approximately 407,000 Medicare+Choice enrollees had to change health plans or switch from Medicare+Choice coverage to Medicare fee-for-service coverage in January 1999. Although the enactment of BBRA and BIPA helped preserve Medicare+Choice coverage for some beneficiaries in some geographic regions, additional beneficiaries were affected by withdrawals and service area reductions in subsequent years due to continuing instability in the Medicare+Choice program. Coverage disruptions were experienced by 327,0000 beneficiaries in January 2000, by 934,000 beneficiaries in January 2001, and by another 536,000 beneficiaries in January 2002. In total, over 2.2 million enrollees have experienced coverage disruptions.

Many of the beneficiaries affected by plan withdrawals have been able to enroll in another Medicare+Choice plan in their area. However, a significant number have been left with only one option—enrolling in the Medicare fee-for-service program, which offers less comprehensive coverage and requires higher out-of-pocket costs than the typical Medicare+Choice plan. Millions more have experienced a reduction in benefits or an increase in out-of-pocket costs, including premiums, even though they were able to keep their Medicare+Choice plans. These benefit changes are a direct result of the underfunding of the Medicare+Choice program.

To underscore the inadequacy of government payments to Medicare+Choice plans, it is useful to compare Medicare+Choice to broader trends in health care spending. Unless Congress acts, CMS projects that in 2003 all Medicare+Choice enrollees will be covered by health plans whose payments will increase by only 2 percent over 2002 payments. In contrast, the Department of Health and Human Services (HHS) has projected that private sector spending by U.S. consumers on all health care services will increase by 9.4 percent in 2002 and that spending increases on prescription drugs are expected to be in the double digits through 2011.

Medicare+Choice Plans Are an Important Option for Beneficiaries

Despite the problems the Medicare+Choice program has experienced in recent years, Medicare+Choice plans have demonstrated that they can provide high quality, comprehensive, affordable health coverage—with a strong emphasis on coordinated care and preventive health care services—that is not available in the Medicare fee-for-service program. This coverage serves as a crucial safety net for many low-income beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program. For all beneficiaries, regardless of their income, this coverage provides access to high quality health care. Beneficiary surveys consistently show that Medicare+Choice enrollees tend to be highly satisfied with their health coverage

Medicare+Choice plans are continually looking for new and better ways to improve the delivery of health care services. By adopting innovative approaches that place a strong emphasis on prevention, Medicare+Choice plans are helping beneficiaries enhance their quality of life.

Medicare+Choice enrollees are benefiting from disease management programs that health plans have designed to improve care for beneficiaries with chronic conditions. A recent AAHP survey, based on responses from 131 health plans, found that 97 percent had implemented disease management or chronic care programs for diabetes, 86 percent had programs for asthma, and 83 percent had programs for congestive heart failure. Health plans also are developing disease management programs for end-stage renal disease, depression, and cancer. Other plans have improved health care for their Medicare beneficiaries through innovations focused on nutrition screening, the relationship between literacy and health, osteoporosis treatment and prevention, overcoming cultural barriers, and promoting clinical guidelines.

Another reason Medicare+Choice plans are popular among beneficiaries is that they typically offer additional benefits not covered by Medicare fee-for-service. According to an analysis by Mathematica Policy Research, 66 percent of Medicare+Choice plans offer some prescription drug coverage in 2002. Last year, other additional benefits available to Medicare+Choice enrollees included physical exams (99.7 percent), vision benefits (94 percent), hearing benefits (79 percent), podiatry benefits (30 percent), preventive dental benefits (27 percent), and chiropractic benefits (5 percent). The lack of adequate funding for the Medicare+Choice program has forced many health plans to scale back additional benefits in recent years.

Medicare+Choice Funding is Inadequate

In both 1999 and 2000, Congress enacted legislation aimed at stabilizing the Medicare+Choice program. At the time these laws were enacted, the Congressional Budget Office (CBO) estimated that the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA) would re-

store a portion of the funds that previously were cut from the Medicare+Choice program.

To better understand how the additional Medicare+Choice funding provided by BBRA and BIPA compares to the deep Medicare+Choice cuts that were made by BBA, it is useful to review the three-year period of 2000-2002. Estimates by CBO indicate that BBRA and BIPA were expected to restore 30 percent, or $5.8 billion, of the $19.2 billion that was estimated by CBO to have been cut from the Medicare+Choice program by the BBA for this period. For several reasons, however, the Medicare+Choice program has not received all of these funds.

One important reason is that, according to CBO's estimates, more than half the additional Medicare+Choice funding provided by BBRA and BIPA was to result from the interaction between Medicare+Choice payments and Medicare fee-for-service payments. Because the growth percentage used in calculating Medicare+Choice payments is linked to growth in Medicare fee-for-service spending—albeit not as directly as under the county-by-county link that existed in the old Medicare risk contract program—Medicare+Choice payments are affected by increases or decreases in Medicare fee-for-service spending. This interaction is sometimes referred to as the "flow-through" effect. Since Medicare fee-for-service spending was increased by both BBRA and BIPA, this "flow-through" effect was estimated to cause an indirect increase in Medicare+Choice payments.

CBO estimated that the "flow-through" effect would increase Medicare+Choice payments by a total of $3.6 billion for the three-year period of 2000-2002. According to research by PricewaterhouseCoopers, approximately $100 million of these funds were received by Medicare+Choice plans receiving floor payments. However, the remaining $3.5 billion was not received because the "blend" component of the Medicare+Choice payment methodology was not implemented in 2001 or 2002. Due to the BBA's budget neutrality requirement and the low Medicare+Choice growth rates of recent years (which are "corrected" annually to account for errors in previous estimates), the "blend" has been implemented in only one year (2000) since the BBA was enacted, and it will not be implemented in 2003 under current law.

As a result, Medicare+Choice plans will receive only $2.3 billion from BBRA and BIPA in the three-year period of 2000-2002, rather than the $5.8 billion that was scored by CBO. This amount represents only 12 percent of the $19.2 billion estimated to have been cut from Medicare+Choice by the BBA in this same three-year period.1Other factors raise questions about whether *even these funds* are reaching the Medicare+Choice program. For example, the Medicare+Choice payment provisions of BBRA and BIPA placed a heavy emphasis on targeting funds toward rural areas where managed care plans are not well-established and where health care providers sometimes are reluctant to contract with health plans. These provisions have had limited success in increasing the availability of Medicare+Choice options in rural areas. As a result, the additional Medicare+Choice spending that CBO anticipated in these areas has not materialized.

Moreover, significant increases in the fees charged by hospitals and other health care providers have absorbed much of the funding that Congress intended to add into the Medicare+Choice program. A related factor is that providers contracting with Medicare+Choice plans face administrative burdens that are both costly and time-consuming, such as the collection of encounter data, that they do not have to deal with in the Medicare fee-for-service program or in the private sector.

The Complexity of the Medicare+Choice Payment Formula Makes It Difficult to Weigh the Merits of Legislative Options. Congressional efforts to stabilize the Medicare+Choice program have been frustrated by the complexity of the Medicare+Choice payment formula. The various components of this formula—the "floor," the "blend," the minimum update, the "carve-out" of graduate medical education funds, the budget neutrality requirement, and the risk adjustment process—interact with each other and, more importantly, with prospective estimates of Medicare fee-for-service growth rates (and retrospective corrections of these growth rates). This interaction makes it impossible to precisely determine how specific payment changes will affect Medicare+Choice payments on a county-by-county basis in future years.

In order to be helpful to Members of Congress, AAHP has tried to provide county rates that would result from specific legislative proposals, using highly sophisticated techniques and the best data available. However, our models are unable to account for one critical factor: Medicare+Choice payments are affected by CMS' estimates of the national growth rate of Medicare fee-for-service spending for every year after 1997, and CMS is authorized to revise these estimates on an annual basis to correct forecast errors from prior years. Because we currently have no way of knowing how much CMS will revise these estimates next year, accurately determining the county

rates that will result from specific legislative changes Congress may enact this year is difficult. This is a serious problem because, although CMS can retroactively adjust payment increases, Medicare+Choice plans cannot retroactively adjust costs.

To understand the degree to which this problem is undermining legislative efforts to provide predictable and stable payments, please consider the following example. In determining Medicare+Choice payments for 2003, CMS revised the Medicare fee-for-service growth rate for 2000 by "1.1 percentage points, by "1.6 percentage points in 2001, and by "1.9 percentage points in 2002, thus causing the Medicare+Choice growth rate for 2003 to be "2.9 percent. When Congress was considering Medicare+Choice payment provisions the previous year, lawmakers had no way of knowing that CMS later would make revisions that would have such a dramatic impact in limiting Medicare+Choice payments. Congressionally mandated payment increases are undermined by a CMS "clawback" due to this forecast error "correction."

New Funding Is Stabilizing the Medicare+Choice Program in Some Areas, but Counties with Many Medicare+Choice Enrollees Need More Help. AAHP estimated that 67 percent of the Medicare+Choice funding provided by BIPA in 2001 went to counties where plans were receiving the floor payment for large urban areas. In most cases, Medicare beneficiaries are better off in these areas because their health care choices and benefits have been stabilized by BIPA. This clearly demonstrates that legislative efforts to strengthen the Medicare+Choice program are worthwhile when plans actually receive the funds Congress intends to provide.

Although BIPA was good news for beneficiaries in large urban areas where counties are now receiving the monthly floor payment, a large majority of Medicare+Choice enrollees have not benefited significantly from BIPA. Currently, more than 66 percent of Medicare+Choice enrollees live in counties where plans received payment increases of only two percent this year. Many of these same plans had received minimum payment increases in each of the past three years (1998-2000) and, unless Congress takes action this year, all counties will receive a payment increase of only two percent in 2003.

Therein lies the problem afflicting the Medicare+Choice program. In the areas where most Medicare+Choice enrollees live, health plans are absorbing cost increases of 10 to 13 percent annually and, at the same time, receiving payments that are increasing by only two percent annually. No organization can survive on a long-term basis when costs continue to outpace income year after year. It is precisely for this reason that many health plans have been forced to withdraw from the Medicare+Choice program, reduce benefits, or increase premiums.

Any serious attempt to stabilize the Medicare+Choice program must directly address the fact that many counties across the nation with large numbers of Medicare+Choice enrollees are in desperate need of additional funding. By acting on the President's recommendation and targeting assistance to these areas, Congress can lay the foundation for broader private sector participation in the Medicare program. If the program is stabilized in these counties, health plans will then be in a stronger position to offer coverage in other counties where choices are not yet widely available.

Claims that Medicare+Choice Plans are Overpaid are Based on Flawed Methodology. The General Accounting Office (GAO), among others, has claimed that Medicare+Choice enrollees are significantly healthier than enrollees in the Medicare fee-for-service program and, therefore, that Medicare+Choice plans are overpaid. AAHP has long disputed the GAO's methodology in arriving at these conclusions. This methodology uses pre-managed care enrollment fee-for-service expenditures (i.e., "prior use") as a proxy for the health status of beneficiaries who are enrolled in Medicare+Choice plans. AAHP has been concerned about the GAO's reliance on this methodology because it includes no information about Medicare+Choice enrollees' use of medical services once enrolled in a Medicare+Choice plan. As a result, the measure used in this methodology bears little relationship to health plan enrollees' actual health status and health care needs.

Specifically, the GAO studies examined inpatient hospital data for Medicare+Choice enrollees to measure health status. This approach can be misleading since care patterns in Medicare+Choice plans emphasize preventive care in order to obviate disruptive and costly inpatient hospitalizations where appropriate. In addition, the cost-sharing requirements in the Medicare fee-for-service program, especially for those beneficiaries without Medicare supplemental insurance, may be high enough to prohibit some beneficiaries from seeking care until they join a Medicare+Choice plan. Indeed, MedPAC found in its June 2000 report that, in 1998, 26 percent of first-year Medicare+Choice enrollees who switched from fee-for-service did not have supplemental coverage in 1997. By contrast, only 13 percent of beneficiaries who lived in a county with a Medicare+Choice plan and who remained in fee-for-service Medicare in 1998 were without supplemental coverage in 1997. Thus,

those joining a Medicare+Choice plan may be more likely to have pent-up demand for medical services when joining a Medicare+Choice plan, making them appear healthier than they truly are under the GAO's methodology.

Notwithstanding AAHP's objections to the GAO's methodology, empirical evidence questions the GAO's finding that Medicare+Choice beneficiaries remain significantly healthier than fee-for-service beneficiaries. Research prepared for CMS found that "the impression that the Medicare fee-for-service population is, on average, in much worse health then the Medicare managed care population is not borne out." (Pope, G.S., M. Griggs, and N. McCall, *Comparison of the Health Status of Medicare Fee-for-Service and Managed Care Enrollees Using the Health Outcomes Survey,* prepared for the Health Care Financing Administration, November 16, 2000.)

Administrative and Regulatory Burdens Are Hampering the Medicare+Choice Program

Another serious problem contributing to the instability in the Medicare+Choice program is that CMS often has failed to consider whether the costs of regulatory requirements outweigh their benefits. CMS has forced health plans to spend scarce resources on compliance activities of sometimes questionable value—leaving plans with fewer resources to spend on patient care. Instead of setting priorities for ensuring beneficiary rights and plan accountability, the agency has created an inflexible regulatory environment that places equal—but arbitrary—emphasis on every requirement.

The Bush Administration has taken important first steps toward improving administration of the Medicare+Choice program. For example, by creating a new Center for Beneficiary Choices, the Administration has consolidated all Medicare+Choice oversight responsibilities at CMS' central office into one single office led by a senior official who reports directly to the administrator of CMS. The CMS regulatory forum held in Phoenix this week, examining the regulatory burdens confronting Medicare+Choice, is also a very positive development.

Additional measures are needed to address other regulatory and administrative issues that are highly problematic for Medicare+Choice plans and enrollees. Equally important, the agency needs to take further steps to eliminate remaining layers of micromanagement and continue to place a strong emphasis on building a reliable business partnership with health plans.

Efforts to solve the crisis in the Medicare+Choice program should include provisions to repeal the Medicare+Choice enrollment "lock-in" requirement and to permanently delay the adjusted community rate (ACR) filing deadline. The Energy and Commerce Committee is to be congratulated for having taken the lead last year in including provisions to move the ACR deadline and delay implementation of the lock-in in the regulatory relief bill passed by the House last December. I hope you will continue your work this year to alleviate these administrative burdens undermining the potential of the Medicare+Choice program.

Stabilizing the Medicare+Choice Program Requires Urgent Action By Congress

I cannot stress strongly enough that Congress should act early in the session to make the changes needed to stabilize the Medicare+Choice program. Health plans are encouraged that President Bush recommended the 6.5% funding increase for minimum update counties in his budget—a good first step. Plans are also encouraged that you are holding this hearing and we ask that you move quickly to mark up and pass a legislative package.

Keep in mind that the regulatory cycle governing the Medicare+Choice program is not consistent with the cycle of congressional activity. Health plans have to make decisions in the next 3 months regarding their participation in the Medicare+Choice program in 2003. If Congress does not act on needed reforms before then, health plans will have no choice but to make their decisions based on current program realities. In that event, Members should expect that additional beneficiaries may lose the health plan choices they value.

No one wants that to happen. To that end, AAHP and its member plans stand ready to assist you as you work to address the serious problems in the Medicare+Choice program. Thank you for this opportunity to appear before you today.

Mr. BILIRAKIS. Well, we have your written testimony, and I apologize for not being here to hear it orally. They make appointments for us, unfortunately, and so we have to go and see these people.

I will start the questioning. Mr. Jindal, some opponents of competition suggest that under an FEHBP model that we are simply herding people into managed care plans. And yet in reality, FEHBP maintains at least six fee-for-service plans in all regions of the country.

Are you aware of any proposal, including the most aggressive, being discussed that would force beneficiaries into managed care plans?

And an additional question in that regard is do the President's principles leave that option solely up to the beneficiary?

Mr. JINDAL. Mr. Chairman, thank you for the question. One of the differences, as I noted in my testimony, is that the majority of employees in the Federal Employees Plan are actually not in HMO type plans, but rather are in the types of plans that aren't even available to the vast majority of Medicare beneficiaries today.

So what the administration is proposing is to increase the numbers and types of choices available to Medicare beneficiaries.

For example, in this year's budget, there is a proposal for the first types of plans to enter new areas so that beneficiaries can have access to preferred provider organizations, point of service plans, and other types of choices that routinely are available to Americans below the age of 65.

So there is absolutely no proposal that we are supporting that would require or force, or even likely result, in the majority of Medicare beneficiaries being enrolled in HMO type plans.

So you are absolutely right to note that the greater diversity of choices in the Federal employees plan and also to note the administration's support to giving seniors those types of choices.

Mr. BILIRAKIS. Any other comments regarding that particular point?

Mr. BUTLER. Maybe I could make a comment on that, please.

Mr. BILIRAKIS. Mr. Butler, please.

Mr. BUTLER. I think one thing that is often misunderstood actually about the fee for service plan within Medicare is that it is in effect a giant managed care plan. The Federal Government, through CMS, and manages doctors directly, and not all doctors are in it.

In fact, my father-in-law just lost his doctor, and he is in his late eighties, and he has many medical problems, because that doctor withdrew simply because of the paperwork and costs associated with it.

So in fact it manages, it regulates, and it directly manages doctors. So it is not true to say that even under the existing Medicare system that somehow this perfect world of complete choice of doctor over here, and then these horrible plans over here.

In fact, there is plenty of bureaucracy within the system on all parts of the program.

Mr. BILIRAKIS. A good point. Ms. Moon.

Ms. MOON. I think that there are a number of things that it is important to remember. One is that we are concerned in the case of Medicare with the level of the premium that individuals would have to pay, and the amount of cost sharing.

And a number of the plans that are not managed care plans in FEHBP now have very large amounts of cost sharing. A number

of those plans that are not managed care plans also are closed to all but the people who belong.

The Mail Handlers Plan, for example, no one else can join the plan except for the mail handlers. And finally the out of network benefits for some that are available are quite different than under Medicare.

It's true, because under Medicare if a doctor takes you in, and most doctors do, about 97 percent, then those doctors agree largely to stick within the amounts that are paid for by Medicare.

There is a little bit of out of network use, but not very much, in terms of balanced billing. In the case of a lot of other plans, my point of service plan, for example, I pay a 60 percent co-pay when I go to my out-of-network physician because the plan puts such a low level of usual, and reasonable, and customary amounts on it that less than half of the costs are paid for.

Mr. BILIRAKIS. Mr. Butler is shaking his head.

Mr. BUTLER. No, I would just like a small correction on what Marilyn said, which is that there certainly are plans, fee-for-service plans, in the FEHBP that are restricted, but certainly not the Mail Handlers Plan, which is open to non-union members.

Indeed, I think there are many members of this current administration that are in Mail Handlers, and I can assure you that they are not members of the Mail Handlers Union.

Mr. BILIRAKIS. Mr. deMontmollin.

Mr. DEMONTMOLLIN. Mr. Chairman, on behalf of the health plans, I would concur with Mr. Butler, and Mr. Jindal, and say that the health plans themselves have no interest whatsoever in there being a lack of choice.

We think that is a critical component of reform in Medicare. We know from our commercial product that if an employer makes us the exclusive provider, we are less likely to be considered a good plan by the members, than if that employer offers a number of different opportunities.

I think the subcommittee needs to be aware that from 1993 to 1997 the Medicare+Choice or the HMO risk program was growing by 30 percent per year. Medicare beneficiaries were very interested in it.

But at no time did it ever get over 15 percent of the total Medicare population. That is to say, 85 percent were always in the fee for service program, and that may be a very good idea.

The concern that we have now is that we are going in the wrong direction. Not only are there only 13.3 percent in Medicare+Choice plans currently today, as of February, but we also know recently from the CBO that those numbers are likely to go down into the 8 percent range if some changes aren't make in terms of the payment of adequate amounts in Medicare+Choice.

There is not a member on this subcommittee I respectfully would suggest that cares any more about the 5 million Medicare beneficiaries who are in Medicare+Choice plans than those plans themselves.

Mr. BILIRAKIS. All right. Now, my time has expired right at this moment. Depending on how many people we have here, and how our time goes, and that sort of thing, and we do have another vote

coming probably within another half-an-hour or so, we may have a second round.

Hopefully we will, because I certainly want to address Mr. deMontmollin regarding my district. I also had another basic question regarding the subject we were on. Mr. Brown to inquire.

Mr. BROWN. Thank you, Mr. Chairman. Listening to the five of you and your testimony, and looking at your written testimony, it occurs to me that this hearing really isn't exactly about Medicare versus FEHBP. It is about making a fundamental change in the program.

It seems that it is about turning Medicare from a defined benefit program, where every senior across the country, whether from Maryland, or from New Jersey, or Georgia, or Indiana, or Florida, or Mr. Strickland's and my State, Ohio, where every beneficiary knows exactly what he or she can count on in Medicare, no matter where they live and what their status, and how much those benefits will cost.

But going from retired benefit into retired contribution, or rather a defined benefit into a defined contribution plan, or voucher plan, where the government gives seniors a voucher and says good luck, Dr. Moon, talk about what such a radical plan change, and what a proposed change from the defined benefit, where people really know what they are getting, to a defined contribution, would mean?

What would a voucher mean for out-of-pocket costs, and what would it mean in defining an affordable plan? What kind of radical change into a voucher program mean for beneficiaries?

Ms. MOON. First, the issue I think is what would make it a voucher plan, and one of the things that is important to think about is how does something move from defined benefit to defined contribution.

It can be done either directly or it could be subtly, and one of my concerns about the FEHBP type approach that it may be very tempting to move subtly toward a voucher. By, for example, requiring beneficiaries to pay substantial premiums above some average amount.

And if that is the case, then it will certainly be a voucher for people who cannot afford to supplement the plan, and they will face very restricted plans that they can choose from.

The other issue I think with the voucher type approach is whether or not it passes all of the risks on to the beneficiary. If the Federal Government decides that it wants to set up a system and allow it to grow at 5 percent a year, for example, but the cost of health care are growing at 10 percent a year, the problem is that all of that will go on to the beneficiary, and it will be leveraged in a way in which the premiums could very easily double over a short period of time.

Mr. BROWN. You mentioned a second ago that people won't be able to afford a certain plan. The proponents of FEHBP, or the proponents of vouchers, often argue that it saves the government money.

It seems to me that it saves the government money by shifting many of the costs on to seniors, correct?

Ms. MOON. I think most of the analyses that have been done have indicated that that is the only way it is going to particularly save money.

There will be some small adjustments for efficiencies, but we have not seen plans come in substantially lower, for example, than what was anticipated it would cost the program to operate.

In fact, that is one of the problems with Medicare+Choice Plans, is that they have not been able to generate enough efficiencies to keep the extra benefits that they had promised.

Mr. BROWN. Well, certainly the Medicare+Choice advocates certainly argued years ago as managed care has become a bigger part, or at least for a while became a bigger part as you suggested of Medicare, and that a big reason for it was to save money, and yet they come with their hand out.

And yet the only money in the President's budget that goes to providers who we read about having a more and more difficult time is for those 15 percent Medicare+Choice providers for those beneficiaries.

Let me shift to Mr. Richtman for a moment. You know, I hear my friends on the other side of the aisle always use the word choice, and it just puzzles me that seniors—they say that seniors get more choice from managed care.

They can choose among this whole menu of plans that offer all kinds of different opportunities and different benefits, and different physicians, and plugged into different lists of physicians and hospitals, and other providers.

And I don't quite get it, because there is no more choice than fee-for-service Medicare. You choose your doctor, and your choose your health facility. What do seniors want?

I mean, is it the plans that they want to choose from, or is it the doctors, or the hospitals? Talk about that if you would.

Mr. RICHTMAN. Well, at the National Committee to Preserve Social Security and Medicare, we conduct a lot of town meetings, often with Members of Congress, democrats and republicans, and I don't think I have ever heard of a senior at a meeting talk about wanting more choices, in terms of plans.

I have heard them talk often about wanting to make sure that the choice of doctors is something that is preserved. That is something that is very important. It is important to all of us, especially to somebody that is older and used to seeing the same doctor.

A member of the subcommittee who is not here at the moment mentioned earlier that seniors are not satisfied with what they get out of Medicare, and that is true to a point. But they are not unsatisfied, I think, because they are denied a choice of plans.

They are unsatisfied because they are still paying a lot out-of-pocket for one thing. The Medicare beneficiary today pays more out-of-pocket for health care as a percent of their income than before we even had Medicare.

It is a pretty amazing figure, and they are not satisfied because they would like benefits to include more preventive care, dental, eyeglasses, hearing aids, immunization, and that is why they are not satisfied.

And, of course, the big issue is prescription drugs, but for the most part seniors are happy with Medicare.

Mr. BILIRAKIS. Please finish up if you would, sir.

Mr. RICHTMAN. Yes.

Mr. BILIRAKIS. Are you finished? I didn't mean to cut you off. I just wanted you to finish up, because time has expired.

Mr. RICHTMAN. Well, I'm finished, Mr. Chairman.

Mr. BILIRAKIS. Dr. Norwood to inquire.

Mr. NORWOOD. Thank you very much, Mr. Chairman. This hearing really is about us taking a look at some alternatives to the Medicare program, FEHBP being one of the thoughts, and I don't want us to get away from that.

Mr. Richtman, I agree with you that at townhall meetings that senior citizens do say they would like to have a choice of physicians. They also say we would like to have everything free.

We would like to have all the health care there possibly is at no cost to us. They do say that. But I am not sure if you ask them rightly that it is a correct thing to say that they wouldn't like to consider choice of plans.

They don't want to be put in a position where they have to choose plans. They want to be put in a position that if they want to stay with fee-for-service, fine. Nobody will bother them.

But they would not mind looking at other plans. So the talking point today of they want choice of physicians and not plans is not exactly correct. I have a lot of townhall meetings, too, and that is a pretty strong statement to make to simply say that nobody wants to have a choice. I wanted to get that out.

Mr. Jindal, you said that there are flaws today in the payment to private plans, and I submit that there are also flaws in the payment system for fee-for-service. In view of the fact of whether we like it or not, there is a limited amount of money out there, and Medicare needs to get some more money in my opinion.

Wouldn't we be better off to deal if we had a limited amount of money and putting that into fee-for-service for which 86 percent of the American people use, versus putting it into private plans, or Medicare+Choice, or HMO, or managed care, or whatever you want to call it, which services about 14 percent of the people.

Now, the answer of course is that we want enough money to put it in both, but I am concerned that we have got a lot of billions of dollars here that we are talking about putting into managed care plans that service the least number of people, simply because frankly managed care was not able to turn up the efficiencies that they said to the government they would in 1973 when we put them into the marketplace basically.

How do you feel about that? Do you think that if we have limited dollars had we ought to spend it on fee-for-service, where most of the people are, or should we put it all into where the fewest number of people are?

Mr. JINDAL. Well, Congressman, certainly the administration has proposed a comprehensive approach looking at all of the gaps in Medicare, and not only the prescription drug issue, but also the lack of a catastrophic benefit in the fee-for-service benefit.

As well as some of the cost sharing that we believe should be updated, as well as the addition of preventive benefits without cost sharing and without deductibles, without applying the deductibles, in the fee for service programs.

And the administration has proposed a comprehensive approach, and you are absolutely right that——

Mr. NORWOOD. But the budget doesn't. The budget says let's put 4 billion into managed care plans, and none into fee-for-service.

Mr. JINDAL. Well, you are right in noting that seniors do want their choices of plans. When you look in recent years and if you look at the non-floor counties and those counties where plans have gotten the minimum update, you have seen since 1998 that some of those plans have grown about 11 percent.

Whereas, fee-for-service in those same counties has grown at 17 percent. So the idea behind the short term money was to simply put a Band-Aid, and not as a permanent fix, but to stabilize the choices so that as we do the comprehensive approach, and that includes $190 billion for prescription drugs and for addressing the gaps in the overall program, there would still be choices for seniors.

But the President is committed to addressing all those issues. It is not an either or. He does want to add the preventive benefits into the new fee-for-service program.

Mr. NORWOOD. Well, you could literally say that the $1.25 billion that is being taken out of the fee-for-service is the money that is being put into the managed care plans where the least number of people are.

I mean, frankly, it just makes no sense to me, but let me go on to another thing. We have got so many things that we need to talk about.

Many of you talk about a prescription drug benefit, and the Lord knows that it makes sense to have one, in terms of just economic efficiency frankly, and thinking with your brain rather than your heart.

Now, the problem with this is that somebody also has to be concerned about what that costs. That is irresponsible to the greatest degree in my view to simply say let's just put anything we need to put into the Medicare program to bet a prescription drug benefit because it sounds good.

And I assure you there is nobody in any townhall meeting who wouldn't say, yeah, you ought to spend it all. Now, presently today Medicare takes up 12 percent of the budget. I view that as a lot.

We do suspect that in the year 2030, without a prescription drug benefit, Medicare is going to take up 30 percent of the budget, one-third of the budget. With a prescription drug benefit, we are guessing at what that might be, but probably 35 percent of the budget.

I would simply like for those of you who said we have got to a full prescription drug benefit. Tell me how you think we can sustain that, Ms. Moon, and Mr. Richtman.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. NORWOOD. I will wait for the next round to get that answer. Just hang on. I'm coming back.

Mr. BILIRAKIS. You all may be thinking about that. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. Dr. Moon, do vouchers mean that some beneficiaries will find that they cannot afford a plan that benefits and that meets their needs if we actually do a voucher plan?

What will it mean if the government gives seniors a voucher and seniors are left to pay the rest of the cost out-of-pocket? Will all the seniors be able to afford a plan with the benefits that they need?

Ms. MOON. I think it depends upon the generosity of the payment that the Federal Government establishes. And the difficulty of a voucher is that then the temptation is to say let's hold the line on costs, and be very tough about this so that we don't over-budget for needs.

It is very difficult in addition to find a way in which the vulnerable beneficiaries will be able to find good plans, because without good risk adjustors, then you will have vulnerable beneficiaries going into plans where they know they need additional services, and that will become even more expensive.

So I think the problem of affordability is going to stretch well beyond low income individuals, and well into people that are 200 percent or more of the poverty level, as well as people who have substantial health care problems.

So I think that the issue of worrying about the costs of Medicare is totally appropriate, but that we should also worry about the costs of Medicare to the beneficiaries themselves, and we already know what they are paying about 22 percent of their incomes, and could pay as much as 30 percent of their incomes on out-of-pocket costs even if policies do not change in the future.

Mr. GREEN. Secretary Jindal, in your testimony, you mentioned that some of the benefit plans in private plans had drug coverage, better preventive care, innovative disease management programs, and other benefits.

Some of us on our panel, especially in the case of prescription drugs, believe that these should be fundamental parts of the Medicare system as we know it today, but fee-for-service and the private plans alike.

If we were to adopt the FEHBP style option, what steps would the administration take to strengthen the fee for service to include these type benefits?

Mr. JINDAL. Well, the President has come out in support, as part of his broad comprehensive approach, of addressing the gaps in Medicare, and he has come out in support of providing access to a subsidized drug benefit for beneficiaries both in the new fee-for-service option, as well as those in private plans.

So we would certainly be open to working with you on the details. Obviously there are differences as has been noted by other panelists between the FEHB and Medicare programs, and are aware of those differences, and want to incorporate relevant policy solutions.

For example, there are special low income protections in the Medicaid program that we think need to continue. We also understand that there is significant private spending on behalf of prescription drug coverage for Medicare beneficiaries today.

And we would not want to displace, for example, all employer provided coverage with government spending. We want to find a way to preserve and to maximize the spending that exists today on behalf of beneficiaries.

Mr. GREEN. And I agree that the President has talked about it, but the difference though is what we see in the budget. And I guess

it is $750 billion for prescription drug benefit, as compared to less than $200 billion for the whole Medicare reform effort. So that is a big gap in there to negotiate on.

Dr. Moon, one of the problems associated with our Federal plan is that frequent withdrawal from the plans from the program, and not unlike our choice plans that we have now, and the fact that enrollees must choose plans each year.

For example, one of my staff had three different plans in 4 years that she has been in the system, and how does this changing of plans affect the health of the enrollees? And isn't continuity of care particularly important in the Medicare population?

Ms. MOON. Studies have shown that continuity of care is important, and actually continuity of care lowers costs. People that don't change their physicians very often, for example, don't have to redo tests, and go through a lot of the other kinds of adjustments that often raise costs in the program.

So I think that is a particular concern, and the stability of plans and the ability of plans to move in and out of the market is very important.

One of the aspects of competition that people celebrate is entrance of plans. We don't usually celebrate withdrawal of plans. But that is a natural part of competition, and something that would happen under any well-functioning competitive system.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Buyer to inquire. We have a series of votes, four votes as I understand it coming up. So after Mr. Buyer, we will break.

And God only knows how much time, but probably a good hour, because two of those are motions to adjourn.

Mr. NORWOOD. Why would we have a motion to adjourn and waste our time?

Mr. BROWN. It's probably because the Rules Committee didn't give us any amendments.

Mr. BILIRAKIS. And that helps?

Mr. NORWOOD. And that is going to fix it, right?

Mr. BILIRAKIS. It really makes a difference. Yes, that fixes it. Mr. Buyer, please inquire.

Mr. BUYER. Mr. deMontmollin, I took to heart your comment about when we did the Balanced Budget Act in 1997 and the goal to get to 25 percent by 2002, and actually we are going in the opposite direction. Does your company participate in FEHBP?

Mr. DEMONTMOLLIN. It does indeed. We have about 15,000 members.

Mr. BUYER. Is there some counsel that you could give us with regard to some of the structures and services within that FEHBP model that could be advantageous if replicated with Medicare?

Mr. DEMONTMOLLIN. Certainly I think that the—and as Mr. Jindal has already said, that the idea of having the same regulations, all of the same programs under the same umbrella if you will, and under the same rubric of this program, so that seniors can make informed decisions.

I suggest that the idea of one solution for all is not going to satisfy the baby boom generation of which I guess I am in the first

year, or the vanguard. We are going to want to feel good, and we are going to want to look good.

And this Congress is going to have to decide if you are going to pay for the looking good part, and I am suggesting that the only way we are going to pay the feel good part, the medical piece, is to adequately fund the entire Medicare program, and offer choice in the way of Medicare+Choice programs.

And not just for prescription benefits, but I may want to avoid the iatrogenic disease of too many doctors giving me too many things, and we would want to have someone that is available to coordinate that care for me.

I may want to have a disease management program that will keep me out of the hospital with congestive heart failure because I know that if I go in twice with that diagnosis that I will be dead within 6 months according to the medical statistics.

I think that they are clearly different programs. I would have to say to Mr. Brown, however, that the suggestion that the FEHBP program is young and healthy is simply wrong. It is a program where we worked just as assiduously to try to keep them healthy, because we see them as the elderly or the most seriously ill persons in 20 years.

At the average age of 45 now, we are trying to intervene at this level so that we don't have to take care of some of these chronic illnesses later.

Mr. BUYER. In your testimony, you said that you hoped the committee will develop competitive approaches to Medicare reform based on a level playing field for all Medicare options.

If Congress were to move and implement any of the FEHBP style, should the government plan be competitive with that of private plans, and should the government plan premium levels be included as part of a weighted average with private plans?

Mr. DEMONTMOLLIN. Yes, it should, and it should because as some have suggested, that 87 percent of Medicare seniors deserve the same high quality care that the 13.3 percent are getting in the Medicare+Choice Plans.

So the answer is, yes. I think that the HEDIS scores should be incumbent upon the fee-for-service plan as well. The disease management, and the things that Mr. Green suggested, that we are doing in the managed care arena because we know that they contribute to improving the health of our seniors.

Mr. BUYER. Give me your 30 second gut check reaction to the Breaux-Frist proposal. Have you had any chance to review it or look at it?

Mr. DEMONTMOLLIN. Well, I have, and I have some opinions about it, but when I am sitting at a table with Bobby Jindal, I will tell you that I am embarrassed to even offer any thoughts, if you would permit me.

Mr. BUYER. Okay. We call that a punt.

Mr. DEMONTMOLLIN. I punted. I told him this morning that I am going to find myself saying a lot what Bobby said.

Mr. BUYER. All right. That's quite all right, and I yield back. Thank you.

Mr. BILIRAKIS. All right. I think it is probably a good time to break, and maybe give you all a chance to grab a bite to eat. I can

not imagine that we would be back before one o'clock, but just as soon as we have cast that last vote, hopefully Mr. Brown and I, at least will immediately return. Thank you.

[Whereupon, at 12:10 p.m., the subcommittee recessed, to reconvene at 1:12 p.m the same day.]

Mr. BILIRAKIS. Well, I am going to start with Mr. Brown's permission. Steve, I would like for you to tell us why AvMed left the Tampa Bay area, and are they interested in coming back into the Tampa area to serve Medicare beneficiaries.

If so, what steps could Congress take to ensure your reentrance and expansion in Florida. And if we were able to help make these adjustments law that you might suggest, could you commit that AvMed would be willing to come back into the Tampa area?

Now, before you go into that, I think it is important—and we don't have Mr. Brown, or any of the minority here, but—that we hear about vouchers and things of that nature. And maybe some of these choice ideas, the FEHBP type of a concept. Frankly an awful lot of senior citizens approach me and say, hey, give us what you have got basically.

And that's why we talk about the FEHBP type of a model, but regardless of whether this is the result, I think Medicare was in trouble long before the majority tax cuts to which Mr. Brown keeps referring.

And I am sure that he is the first one to admit that. But is it not wise that we not prejudge, and is it not wise that we be open-minded to the possibility of new concepts or new ideas?

Would any of us be a party to doing anything regarding Medicare that would hurt the quality of medical care for our Medicare beneficiaries? I think not.

So, it is really more the case of trying to be open-minded and looking at new ideas, and that sort of thing. I don't think we should have any preconceived positions on these ideas.

I will ask this question again before I go to Mr. deMontmollin. And maybe, Steve, we can start with you on that. When we do, with the cooperation of the Minority, and open-mindedness on the part of the Members of Congress, we will finally do prescription drugs for Medicare beneficiaries.

Now, is it going to be all that we would rather it be? It probably won't be, but it will be a darn good start. I am not talking about the President's discount card sort of thing.

But will it be something that will help an awful lot of people in the meantime? I would like to think so. We could have done a lot of good things over the years if we maybe were not so political and concerned about all or nothing.

We could have had some good approaches on the uninsured a few years ago, for instance, and we could have had an expansion of Medicare into prescription drugs, and things of that nature.

I know that is always a concern on the part of my very good friend, and we are good friends. I know that we all throw those words around about each other while we attack each other, but the truth of the matter is that we are good friends, and I am very proud of that.

But my good friend and others might be concerned that if we do something that is not quite what they would completely like, that we would stop at that point and not improve upon it.

Well, we are elected every 2 years by the people, and I should like to think that we would continue on and try to improve as the years go on. In the meantime, why deprive many of the people, particularly the needy, and mainly the poor, from some sort of a benefit that they could have, and I would like to think, virtually now?

But I would like to raise a question. If we do—and I keep saying if, and I don't really mean if, because my intent, and the intent of all of us and the President's intent, is that we have prescription drugs this year.

But what would that do to Medicare+Choice? We keep talking here about Medicare+Choice, and we keep talking about the different plans, the FEHBP, and the choice in terms of Medicare+Choice, and of managed care plans.

But what would that do to that? I mean, my opinion, Max, and when I talk to people, and you know how much time I spend with the elderly in my district, of which I am one now, is that their care is about prescription drugs principally, and if we give them prescription drugs, will they continue in managed care?

Or would they just shift into fee-for-service? Do you have any opinions on that? Very quick opinions though, because I do want to answer the long——

Mr. DEMONTMOLLIN. I promise, and let me suggest, Mr. Chairman, that the American Association of Health Plans wants to be a part, only a part, of an overall bipartisan solution. I had the privilege of working for 6 years on the Hill for a member of the minority party, who was Chairman of the House Committee on Science and Technology.

In 1987, the Democratic Leadership Council, then with Governor Clinton, and then Senator Gore, and then Senator Chiles, for whom I also worked in 1990 when he was Governor of the State of Florida, they came up with a concept called managed competition.

And they were willing to give that an opportunity to work in the marketplace. For some reason according to what I have gleaned from this meeting today, that has been thrown out the window as a viable political alternative for the minority party. I will say this. That in 2 weeks before the——

Mr. BILIRAKIS. Excuse me, Steve, but did you want to respond before you leave, because you did tell me that you had another meeting that you had to go to?

Mr. BROWN. As does Dr. Moon.

Mr. BILIRAKIS. Yes, Marilyn has already said that to me. Do you mind yielding?

Mr. DEMONTMOLLIN. Please let me defer. No, absolutely.

Mr. BILIRAKIS. Go ahead, sir.

Mr. JINDAL. I apologize to both the committee and the chairman, but I am going to have to leave. I didn't mean to interrupt the gentleman from Florida's remarks. I do want to offer in response to the chairman's comments and questions two thoughts.

First of all, we certainly do believe that with the President's overall reforms that it will stabilize the market, and one of the rea-

sons that we are proposing these changes are to increase the numbers of choices available to seniors.

And as you had asked before, certainly that is not to compel seniors to do something, but rather to give them choices, and we don't believe this is either a voucher program, or as you asked, we don't believe it is a defined contribution program.

Our predecessors, there was some allusions to other proposed concepts, and the last administration also had proposed a defined benefit competition model. So we do think there are some important safeguards, and some important protections for seniors that differentiate what we are talking about doing with some of the concerns that folks have about pure voucher programs or pure defined contribution programs.

And I do look forward to coming back and talking to the committee in greater detail. I do apologize for having to leave today, but thank you, Mr. Chairman, for the opportunity to come.

Mr. BILIRAKIS. The intent always is that we would have the current benefits at least be a floor so that every plan—it would be a defined benefit type of a plan, in terms of the benefits?

Mr. JINDAL. That's right. We are not proposing to erode the value of the current benefits, and certainly we are hopeful, and I think the experience has been that those plans are more likely to reduce the cost sharing faced by beneficiaries, and we think it is important to give some constrained amount of flexibility, in terms of cost sharing.

But, no, we are not proposing to reduce or dilute the value of the benefits. The President is talking about adding a prescription drug benefit, and preventive care benefits, and reforming cost sharing.

Mr. BILIRAKIS. Thank you very much for your time.

Mr. JINDAL. Thank you, Mr. Chairman, and thank you members of the committee.

Mr. BILIRAKIS. Ms. Moon.

Ms. MOON. I would just say that for purposes of fairness and it makes sense to have a prescription drug benefit offered across the board, and I think that would lead to higher payments to managed care plans, which would solve one of their problems.

And that is that they cannot, they believe, offer such benefits without additional payments. And they are sort of caught between a rock and a hard place, where they are being paid enough for Medicare covered services, but the Medicare covered services are not enough to do a good managed care benefit when you leave things like prescription drugs out.

So I think that could help managed care plans be more competitive and come to a better financial footing if we did that, but for fairness reasons, I think it has to be done across the board.

Mr. BILIRAKIS. Thank you. And again thanks for your contributions today, and also over the years.

Mr. NORWOOD. Can I ask a quick question?

Mr. BILIRAKIS. Well, if she has the time, by all means.

Mr. NORWOOD. Just very quickly. When I left off and didn't get answers, my basic question was those of you who stated that we needed to have a prescription drug plan across the board for everybody.

Ms. Moon, should we as Members of Congress be concerned at all that a third of the budget in 2030 will be going to Medicare if we do that?

Ms. MOON. Yes, I think we should always be concerned about that. Medicare though has been a program that has always been on the verge of bankruptcy. It is actually in the best shape it has been in since almost the beginning of the program, in terms of how well it is situated.

I believe though that a prescription drug benefit is essential to having reasonable benefits. I think the beneficiaries are going to have to pay more, and I think taxpayers are going to have to pay more.

And I think we are going to have to be very serious about finding ways to contain costs. Let me give you just one example. Maine is doing some very creative things with its low income benefits program for prescription drugs by restricting access to some of the drugs.

You have to have prior authorization for things like Celebrex and Vioxx. You have to have a good reason for that. But then they turn around and cover the over-the-counter drugs that can be used in their place, like ibuprofen.

I think they are doing some creative things there. I think if you do it intelligently that you can have very stiff controls, but on the basis of good medical care, and not just on the basis of price.

Mr. NORWOOD. Well, would a creative thing be that you don't add Ross Perot in the list of recipients of Medicare prescription drugs?

Ms. MOON. That is a toughie though because Medicare has been such a powerful program, and so popular because it is universal.

And if there were lots of Ross Perots out there, I would be on your side. I am not theoretically opposed to some kind of income relation to the benefit or asking higher premiums, or whatever.

But it tends to lead to lots of expense for taking just a few people off the rolls, unless you go way down. And in the case of Medicare, $15,000 or $20,000 of income, which are not poor Medicare beneficiaries, as they are people who are sort of almost into the middle class the way we talk about them, cannot afford prescription drugs these days.

Mr. NORWOOD. So your answer is that it would be all right with you if a third of the entire budget of the United States went to Medicare and prescription drugs?

Ms. MOON. I don't think that is the way that it will turn out because those projections are based on the way that we define its progress.

Mr. NORWOOD. What is it did?

Ms. MOON. Well, if it did, it would say that we will have doubled the number of people who are covered by this program over that period of time, and so we should increase the Medicare program to some extent as a share of the budget.

Mr. NORWOOD. And if we double the number of people that are covered, what happens to the number of people that are paying in?

Ms. MOON. They go down, but they also get healthier. The size of the pie will be larger, and so the slice that we can use for it will be okay.

Mr. BILIRAKIS. Mr. Brown, would you like to address anything of Ms. Moon?

Mr. BROWN. Yes, I would like to follow up on that. You put a chart out that I think we have all seen that compares the cost increases of Medicare since 1998, and up through the year 2002 with the cost of premiums with FEHBP. And I share Mr. Norwood's concern of entitlements, social security, Medicare especially.

And taking money from the next generation if you will, and particularly the young, and we have done so very well in this country relatively with the elderly, and not so well with the young.

And I think that we all share that concern for investment in the future, but I think that one answer to that is what in fact we do about it, and we found ways, and sometimes overdone, to rein in the class of Medicare.

And we have not done so well with FEHBP as it says, and I think that comes back to what are we as a society going to do.

And I want to enter in the record if I could, Mr. Chairman, one article that is written by Paul Krugman in the New York Times about how physicians, commenting on physicians, a 5.4 percent cut with physician payments and all that has happened with the 15 percent cut for home health care, and all that we are facing that way.

And how it seems that in Washington we are starving the public sector with tax cuts and other ways so that we don't have the kind of resources available to have the right kind of health care in other systems.

And if I could, Mr. Chairman, ask for unanimous consent to enter in the record Mr. Dingell's statement also.

Mr. BILIRAKIS. Without objection.

Mr. BROWN. And the testimony of Janice Lachance, former OPM Director, and the Alliance for Retired Americans statement, and also there is a chart comparing what beneficiaries get in FEHBP.

Mr. BILIRAKIS. Without objection, that will be the case, and of course per usual, all members have the opportunity to have their opening statement made a part of the record.

[The material follows:]

Alliance for Retired Americans

NEWS RELEASE

888 16th Street, N.W., Suite 520 ♦ Washington, D.C. ♦ (202) 974-8222

For Immediate Release
March 19, 2002

Contact: Rich Fiesta (202) 974-8227

Statement of the Alliance for Retired Americans

Hearing of the Committee on Energy and Commerce
Subcommittee on Health

Use of the Federal Employee Health Benefit Program
for Making Changes to Medicare
March 20, 2002

MEDICARE NEEDS RESOURCES AND DRUG BENEFIT NOT PRIVATE MARKET VOUCHERS

WASHINGTON DC — The Alliance for Retired Americans rejects proposals to restructure Medicare under a voucher-based, Federal Employees Health Benefits Program (FEHBP) model. The FEHBP model would destroy Medicare as a social insurance-based system that has had decades of success.

The FEHBP has no relevance for the needs of Medicare beneficiaries. The FEHBP provides health insurance for a different population than does Medicare. Federal employees are younger, healthier and have higher incomes. In addition, Medicare has benefits guaranteed by statute while benefits under FEHBP are negotiated and are subject to change. The cost of insuring Medicare beneficiaries is three times that of covering the healthier and younger federal workers.

The FEHBP competitive system uses heavy and intensive marketing techniques that do not work for the Medicare population. In the federal service, unions, professional groups and the Office of Personnel Management serve as advocates and public educators regarding the various plans. For forty million Medicare beneficiaries, no such informational and advocacy structure exists.

The Alliance for Retired Americans supports every effort to assure a more effective and efficient Medicare program. Millions of seniors and persons with disabilities, together with their families and health care workers who treat Medicare beneficiaries, agree that the focus of Medicare improvements in the short and longer-term must be the guarantee of first-class care for all Medicare beneficiaries. A continuation of that guarantee, together with the incorporation of a comprehensive pharmaceutical benefit, must be the core of changes to the Medicare program.

The Alliance recognizes there are systemic shortcomings in Medicare, in addition to the lack of a comprehensive drug benefit. Medicare needs coverage for dental and vision care, routine preventive care such as check-ups, more and affordable long-term care services and a cap on all out-of-pocket costs. Seniors now spend twenty percent of their income for health care and the older and poorer you are, the higher that proportion grows. Medigap policies are becoming increasingly unaffordable and Medicare+Choice plans are dropping seniors by the millions. In addition, employer sponsored retiree health benefits are rapidly being cut back in coverage or eliminated altogether.

There is no evidence that a FEHBP model will meet these needs nor build on the successful components of the existing program. Instead, the Medicare program and its forty million beneficiaries face a crisis manufactured by the 2001 tax cuts which are depleting the entire Medicare surplus. The Medicare program is being held hostage by the House Budget Resolution, which states that Medicare must be "modernized" before funds for a prescription drug benefit program are released. Today's hearing on the FEHBP model for Medicare is a part of a plan to destroy the Medicare program by forcing it into a voucher, private market model and to underfund the most important unmet need of Medicare beneficiaries – a prescription drug benefit.

Under a competitive model, private insurance companies will intensely recruit younger, healthier and more profitable beneficiaries leaving the older and sicker eligible persons to the traditional Medicare program, driving up fee-for-service costs, premiums and out-of-pocket expenses beyond the reach of most seniors. Many persons using the traditional Medicare program will have high risk of losing their existing physicians and other health-care providers who may not participate in affordable private, FEHBP-model Medicare plans. Finally, in earlier Breaux-Frist proposals outlining the utilization of the FEHBP model for Medicare, beneficiaries would have to purchase private plans to receive any level of prescription drug coverage. There are unacceptable alternatives for Medicare beneficiaries and the Alliance for Retired Americans urges Congress to reject the privatization of Medicare.

The Alliance for Retired Americans is a nationwide organization of more than 2.5 million union retirees and other older and retired Americans working together to make their voices heard in the laws, policies, institutions that shape our lives.

STATEMENT

OF

THE HONORABLE JANICE R. LACHANCE

MANAGEMENT CONSULTANT AND FORMER DIRECTOR OF
THE U.S. OFFICE OF PERSONNEL MANAGEMENT

ON MEDICARE MONDERNIZATION: EXAMINING THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AS A MODEL FOR SENIORS

FOR THE

U.S. HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HEALTH

MARCH 20, 2002

Introduction

I am honored to have been invited to submit a statement to your Subcommittee on this important topic. I regret being unable to join you in person but I look forward to assisting you in your deliberations however I can.

I had the great privilege of serving as the Director of the US Office of Personnel Management (OPM) from 1997 until 2001. I began my tenure at OPM in 1993 as the agency's Director of Communications and went on to hold the positions of Director of Communications and Policy, Chief of Staff and Deputy Director before being nominated and confirmed as Director.

Throughout my years at OPM, I worked closely with and, ultimately, directed the dedicated public servants who administer the Federal Employees Health Benefits Program (FEHBP). I know first-hand that these Federal employees are the principal reason the FEHBP is often considered a model health insurance program. Their commitment to the 9 million persons who receive their health care through FEHBP is unsurpassed and their ability to manage a program of this size and scope, in such an efficient and effective way, is simply outstanding.

As our nation wrestles with the complexities of the health care challenges we face, there are many reasons to look to the FEHBP for lessons learned, but it is important to be ever mindful of the uniqueness of this program, its reason for being, and its recent challenges before it is advocated as a solution to America's health care problems.

For several years now many have said that if the FEHBP is good enough for Federal employees, it is good enough for the millions of other Americans who need affordable health insurance. Nevertheless, before you take that step, I believe you should weigh whether today's FEHBP is even good enough for Federal employees.

Background and Structure

As this debate proceeds, it is important to keep in mind that the FEHBP and Medicare have fundamentally different missions. The FEHBP is an employer-sponsored health insurance solution that is but one part of an overall compensation package offered by the Federal government to attract and retain employees who perform the important work of our government. In other words, FEHBP is not a model for an entitlement program.

The vast majority of FEHBP enrollees are either Federal employees who have steady income or Federal retirees who have earned an annuity. Although this is becoming increas-

ingly difficult, the FEHBP was conceived on the principle that current and former public servants have the financial ability to contribute to their health care coverage by paying a portion of their premium in addition to their out-of-pocket expenses.

An additional difference in the two programs is their size. While OPM demonstrates a strong expertise in arranging health coverage with hundreds of private sector health plans across the nation and around the world for a covered population of approximately 9 million, the FEHBP is dwarfed in size by the Medicare program's enormous number of enrollees and providers.

Further, the approximately 200 plans participating in the FEHBP provide a core set of benefits required by OPM. But, there is no, single, standardized benefits package. So, even where the benefits of alternative plans are nearly identical, cost sharing provisions can differ significantly among them.

These distinctions are important to FEHBP enrollees, who have an array of resources available to assist with choosing their health insurance plan. OPM works with the health care plans to design their plan brochures in a standard format that helps enrollees easily identify changes in coverage and compare plans. OPM has also launched an on-line program to help enrollees select the plan most suited to their particular circumstances. Individual employing agencies provide materials and counseling for their employees. In addition, all aspects of the FEHPB receive detailed coverage in the free media and a number of commercial enterprises publish annual guides to the program and its plans. While the Medicare program broadly disseminates general and comparative information, there exists no comparable established structure to educate or even simply inform the millions of Medicare recipients.

Accordingly, from a practical operations management perspective, it does not seem at all possible to simply expand the scale of FEHBP to serve the enormous number of Medicare recipients.

Enrollee Costs

The greatest concern to those involved in Medicare reform should be the staggering spikes in FEHBP premiums over the last several years. In fact, the current rates are almost 50 percent higher than they were just a few years ago in 1998. The five consecutive years of

premium increases have sent shock waves through the Federal workforce and among those living on a Federal annuity. The annual increases were:

- 2002 – 13.3 percent
- 2001 – 10.5 percent
- 2000 – 9.3 percent
- 1999 – 9.5 percent
- 1998 – 7.2 percent

The 2002 increase is the FEHBP's largest since the late 1980's, when premiums rose almost 19 percent in a single year.

It is also important to keep in mind that these are average increases. The premiums of some of the most popular plans went up significantly more. For example, the Blue Cross and Blue Shield plan, which covers about half of the program's participants, posted increases of 17.2 percent for its family coverage and 20 percent for "self-only" coverage.

And, experts within and outside OPM see no end to the annual double-digit increases in premiums.

OPM attributes the premium spikes to three factors:

- First, the rising cost of prescription drugs;
- Second, the increased use of medical services;
- Third, the aging of the covered population.

While the jumps in premiums have paralleled those of other large public and private sector employer-sponsored programs, there is little doubt that these spikes have made FEHBP coverage unaffordable for tens of thousands of lower-income Federal employees and for tens of thousands of retirees who simply can no longer afford to pay the enrollee share of the premium.

The typical Federal employee who covers his family now pays $92.10[1] every two weeks, an increase of $11.57 per pay period over last year. The single employee now pays $40.89[2] every two weeks, an increase of $4.32. Clearly, these are now very significant deductions from the take-home pay of many Federal employees.

1. $2,394.60 annually
2. $1,063.14 annually

In an effort to make FEHBP more affordable, OPM implemented a premium conversion plan in 2000 that enables Federal employees to use pretax dollars to pay their premiums. The benefit saves the typical employee approximately $435 per year, yet it merely mitigates, and does not solve, the affordability issues.

Tragically, it now seems likely that tens of thousands of public servants with steady, full-time jobs can no longer afford the health insurance that is an integral part of their compensation package and annuitants who dedicated their careers to the Federal government can no longer count on being able to pay for the health insurance they need.

Until the affordability issue is thoroughly examined and the reasons for the premium increases completely understood, I would urge the Members of this Subcommittee to proceed with extreme caution before applying the principles of FEHBP to Medicare.

Demographics

Before applying FEHBP principles to Medicare, the Subcommittee must consider the customer bases of the two programs. They are fundamentally different. In the FEHBP, the members are almost equally divided between active employees and retirees. In addition, many of those retirees are younger than age 65. These demographics are a dramatic departure from Medicare's, where most participants are 65 and over.

One of the reasons cited for the FEHBP's recent premium increases is the gradual aging of the Federal workforce, but no matter how old the FEHBP population, it will always be substantially younger than the Medicare population.

The fact that the Medicare population is so much older will no doubt amplify the problems associated with controlling the costs of FEHBP premiums placing financially vulnerable Medicare recipients in the same untenable position as those who can no longer afford FEHBP coverage.

Prescription Drugs

The national debate over Medicare also includes the question of whether to provide a prescription drug benefit, and the shape of such a program. There is no doubt that Medicare enrollees from all walks of life desperately need relief from the ever-increasing costs of prescription drugs and as policy makers, I am sure you want all Americans to be able to access the latest advances in drug therapy whenever needed.

As you consider this issue, I urge you to keep in mind that the FEHBP, as it is currently structured, has failed to curb the rising costs of prescription drugs. These cost levels have a direct correlation to the age of the covered population. A general observation can be made that young people use prescription drugs for short time periods while recovering from an illness while older people will use prescription drugs for extended periods to treat chronic conditions. Within the FEHBP, OPM's 1999 statistics show the average prescription drug expense for an enrollee aged 45 to 49 was about $400 per year, but for someone aged 65 to 69 it was three times that amount.

Conclusion

For most of its 42-year existence, the FEHBP has been the centerpiece of a compensation package that attracted the best and the brightest into public service. Unfortunately, the dramatic premium increases of the last several years and the likelihood of such increases in the future lead to important questions concerning the FEHBP's viability not only as a model for other health insurance needs but even as an advantageous employee benefit in its own right.

Those who argue for the status quo say that the FEHBP experience is no different than that of other large employers and, eventually, its status as a model health benefits system will be restored. However, I fear the problems of the FEHBP and similar premium support systems are of a magnitude too great to be easily repaired and will continue to push more and more Americans into the ranks of the uninsured because their coverage will simply become unaffordable.

As an employer, the Federal government owes its workers a meaningful health benefit. As a nation, we owe Medicare beneficiaries a system that meets their needs.

THE NEW YORK TIMES TUESDAY, MARCH 1

PAUL KRUGMAN

Bad Medicine

Sunday's front-page article in The Times on doctors who shun patients with Medicare may have been alarming enough; it seems that recent cuts in Medicare payments are inducing many doctors to avoid treating Medicare recipients at all. But this is just the beginning of a struggle that will soon dominate American politics.

Think of it as the collision between an irresistible force (the growing cost of health care) and an immovable object (the determination of America's conservative movement to downsize government). For the moment the Bush administration and its allies still won't admit that there is any conflict between their promises to retirees and their small-government ideology. But we're already past the stage where this conflict can be hidden with fudged numbers. The effort to live within unrealistically low targets for Medicare expenses has already translated into unrealistically low payments to health-care providers. And it gets worse from here.

Why do health care costs keep on rising? It's not because doctors and hospitals are greedy; it's because of medical progress. More and more conditions that once lay beyond doctors' reach can now be treated, adding years to the lives of patients and greatly increasing the quality of those years — but at ever greater expense. A triple coronary bypass does a lot more for you than a nice bedside manner, but it costs a lot more, too.

During the 1990's the upward trend in health care costs seemed to level off. But it's now clear that this was a one-time cost squeeze due to the shift to H.M.O.'s. Now medical costs have resumed their upward march.

If medicine were purely a private matter, medical progress would pose no more of a dilemma than, say, progress in home entertainment systems. But in fact the United States, like every advanced country, treats essential health care as a right, not a privilege. Our Medicare/Medicaid combination provides this right somewhat haphazardly; still, the intent of our system is that nobody should be denied life-saving treatment for lack of funds.

Why don't we just leave medical care up to individuals? Basically, even in the United States there are limits to how much inequality the public is prepared to tolerate. It's one thing if the rich can afford bigger houses or fancier vacations than ordinary families; Americans accept

such differences cheerfully But a society in which rich people get their medical problems solved, while ordinary people die from them, is too harsh even for us.

And so we have Medicare and Medicaid. And the public overwhelmingly supports the extension of Medicare to include prescription drugs, for the same reason: it seems wrong to most Americans that drugs that make a big difference to people's lives should be

Return of the health care crisis.

available only to those wealthy enough to pay for those drugs out of pocket. Including drug coverage in Medicare is not so much a matter of extending the program as of remaining true to its original intent.

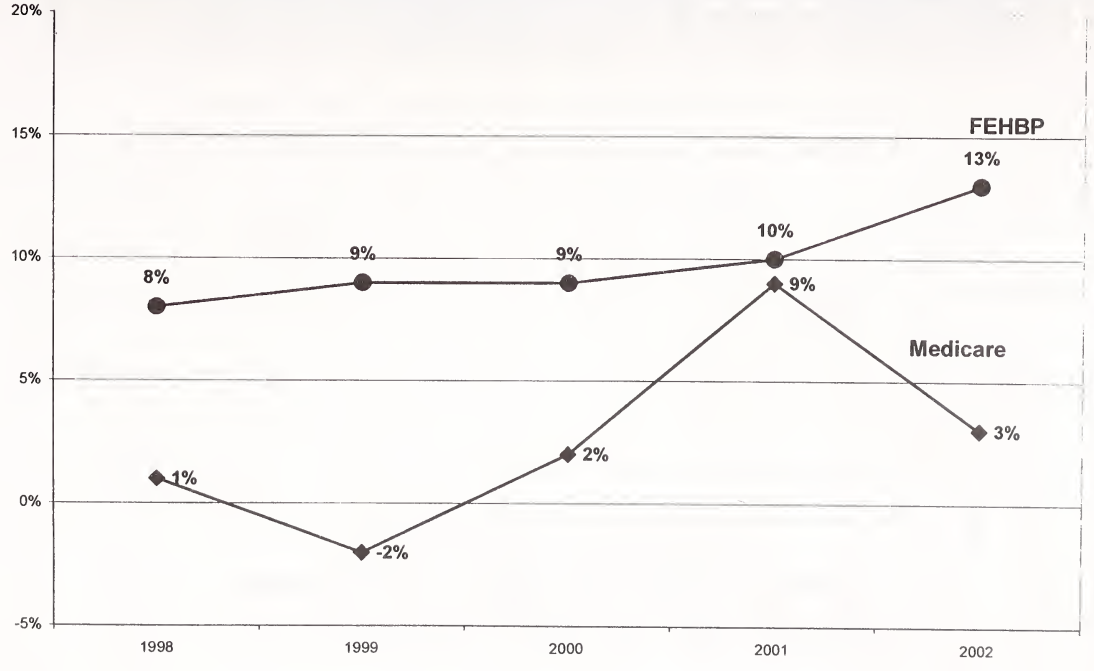
But meeting the public's expectations for medical care — that is, ensuring that every American, and in particular every retired American, gets essential care — will require a lot of government spending And the conservative movement in general, and the Bush administration in particular, are not prepared to make the money available; after all, government spending must ultimately be paid for with taxes.

Yet they dare not say openly that they are prepared to deny essential health care to those who cannot afford it. So what can they do?

The Bush administration is still trying to fake it; the budget proposal it released last month had health-care economists rubbing their eyes. It assumed a far lower rate of growth in Medicare expenses than anyone else thinks plausible — over all, it budgeted $300 billion less over the next decade than the nonpartisan Congressional Budget Office projects will be needed And it also repeated the implausible claim that we can have prescription drug insurance on the cheap — setting aside half or less what others think such a program will cost.

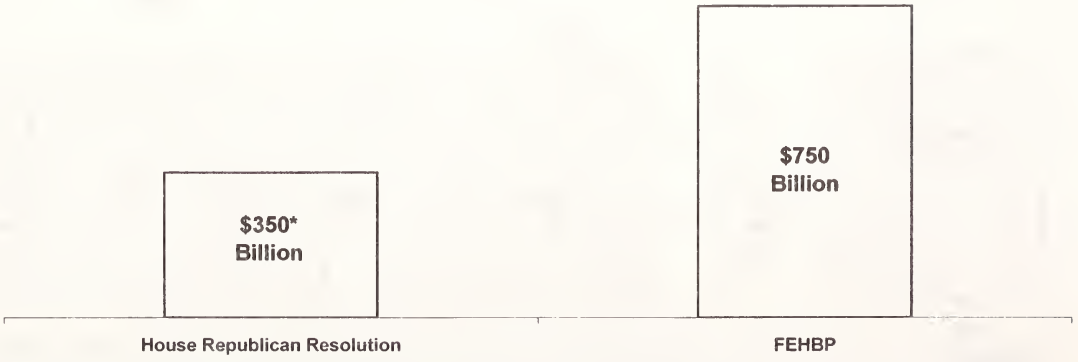
But we have already reached the point at which we must either come up with more money or deny health care to reprees. The moral of Sunday's article is that Medicare payments have already been squeezed beyond their limits, to the point where recipients can't find doctors willing to take them. Something will have to give, and soon. □

Medicare Outperformance FEHBP In Last Four Years
(premium growth/ per capita growth rate)



Sources: OPM, OBM, historical outlays and Medicare Trustees Report

Budget Not Enough to Provide Medicare Beneficiaries With Same Drug Benefit As Members of Congress



Source: Based on CBO Ballpark Calculator for Medicare Outpatient Prescription Drugs, 4/13/01; increased by 15% to account for new budget window and drug inflation. Adds $60 billion for low-income supplemental benefit. "FEHBP" is based on Blue Cross Blue Shield Standard Option for 2002, which has beneficiaries pay 30 percent of the premium and 25% coinsurance for drugs at retail pharmacies (no deductible or stop-loss).
*This estimate is the most favorable look at the Budget Resolution numbers: (1) the $350 billion becomes only $124 billion when using the CBO baseline; and (2) the amount allotted also includes money for provider givebacks as well as drugs, so the true number for prescription drugs is less than is less than the total of $350 billion (or less than $124 using CBO estaimates).

Mr. BILIRAKIS. Ms. Moon, I know that you have to leave. Thank you again.

Ms. MOON. Thank you.

Mr. BILIRAKIS. All right. I am just going to continue on with the previous question that I asked Mr. deMontmollin.

Mr. DEMONTMOLLIN. In September of the year 2000, a representative of John Podesta's domestic policy shop in the White House said at a Medicare and Medicaid conference sponsored by the American Association of Health Plans, that we found it necessary to engineer a failure of the Medicare+Choice program to make it more palatable to have a publicly funded program for prescription drugs.

We think that is a failed and a bad policy. And to answer your question directly, however, we believe that there is more than enough room in the Medicare program to adequately fund and stabilize the funding for Medicare+Choice plans, which will also be offering prescription drugs for the very salient reason that it began probably 7 or 10 years ago.

And that is that we recognize the important role that pharmaceuticals play in health care today. So we saw this as a value added. We saw it as something that we needed to do from a quality standpoint.

Two weeks before the 1998 election, the Florida Insurance Commissioner and the Florida Attorney General announced an investigation into the reasons for the withdrawal by several Medicare plans, including my own, of their products in selected counties.

Interestingly, the press release issued by the Florida Attorney General acknowledged that Medicare HMOs provide Florida's senior citizens, quote, convenient, affordable health care and any threat to their ability to obtain such care, that is, managed care, is a threat to their fundamental well-being.

And I would suggest that it was ironic at best that the managed care companies that had been the whipping boys for more than 4 years suddenly became or suddenly their availability was a fundamental right of seniors.

And I think that is the question that Congress is going to have to answer. We in managed care may very well be the dinosaurs of the health care system. But I don't think that we should go away quietly. I think we should make the case on quality, and make the case on increasing access to health care.

There are 40 million of Americans that I believe that I am speaking for right now. Make the case on moderating the cost of health care expenditures in this country. If we don't have a system of managed care, we are going to go back to a system of unmanaged care, uncontrolled care, and we think that our citizens are going to be poorer for it.

Mr. BILIRAKIS. Of course, Mr. Butler indicated that our fee-for-service plan is in fact managed care, and so there is some management there. What is it that the President has proposed, a 6.5 percent increase, or $4 billion?

Mr. DEMONTMOLLIN. 6.5 percent increase and $4 billion. Let me answer it this way, Mr. Bilirakis. We hated to leave all of the counties that we have had to leave in Florida.

We are Florida's, as I have already said, oldest and largest not for profit HMO. We see as our mission serving the Medicaid population, and the Medicare population, and we do a good job of serving both of those populations when we are given adequate funds to do that.

In Florida, Chapter 641 of the Florida statutes, require every health plan to make at least a 2 percent profit and to have at least 110 percent of assets, as compared to its liabilities.

AvMed Health Plan has lost $32 million directly associated to the Medicare+Choice reductions from the Balanced Budget Act, and I will be happy to demonstrate that to every member of this subcommittee, and to your staffs.

I have already invited the staff to please come to my health plan to find out that we offer a heck of a lot more than just simply a pharmaceutical program, although we are going to continue to do that, and the best predictor of future behavior is past behavior.

Mr. BILIRAKIS. For instance, in terms of the fee-for-service that would be available to these same beneficiaries, what do you offer?

Mr. DEMONTMOLLIN. My mother was 89 years old and in the South Miami Hospital, and a doctor wrote in her medical chart iatrogenic disease. Too many doctors. It is the same finding that the Institute of Medicine found when they said that more is not necessarily better.

The existence of coordination and arrangement of health care is just as important as the financing of health care in our opinion. She was not able to be a part of our congestive heart failure program, where as soon as we identify a patient, every one of our patients—and there was a recent study that was issued with respect to diversity.

And I am saying every single one of our patients is placed into, or has the opportunity to be placed into the congestive heart failure program. We buy a scale that allows for interactive response to a computer at our health plan from all of these members, and they get up in the morning, and they get up on the scale.

And we are able to check from their responses whether or not they are compliant with their medications. If they are not, we can send a nurse out to administer an injection of the medication.

But we are following those members on a one-to-one basis. It is those kinds of programs; the HEDIS measures, and the fact that we credential all of our physicians.

You don't have to worry about whether or not there is an external grievance appeal process in place in the health plans because Mr Norwood and other right-thinking people in this legislature in our opinion have made sure that those external and internal appeals processes are available for members in the Medicare+Choice program, and we take them very seriously.

If you will have a staffer come in and put on the headphones, and listen to our conversations with some of our members, and find out if we are trying to probe them, and find out if there are additional resources or services that we can provide them that they are simply not aware of.

Mr. BILIRAKIS. All right. So I guess what I am interpreting is that in response to my question, if we offer prescription drugs as

part of Medicare, would the seniors continue on in managed care plans?

Mr. DEMONTMOLLIN. I am speaking for our almost 30,000 members in Florida when I say that they don't see these increases—for instance, BBA, and BBRA, and BIPA—as being monies that go to the health plan.

As I have already said, we have lost $32 million since the Balanced Budget was passed, and what they see is those funds being denied to them because they know that they are being passed on to them.

Mr. BILIRAKIS. Well, time is a factor here, but we will of course have a lot of written questions, and give you an opportunity to really go into details.

Mr. DEMONTMOLLIN. Thank you.

Mr. BILIRAKIS. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman, and Mr. Chairman, I apologize to you and the other members, but this has been one of those days when I have not been able to be here as much as I would like to be because of other responsibilities.

I am going to ask a question that I suspect has been touched on already, but I would like especially to get your reaction, Mr. Richtman, to this question. Currently participants in Medicare basically pay the same premium, and share the same costs, and are entitled to the same benefits under Medicare, regardless of where they live.

But under a premium support plan, premiums for different health plans would vary perhaps widely across the country. For example, a Federal Employee's share of the monthly premium for Aetna USA Health Care is $56 per month for a Federal worker in Arizona, and $73 in Virginia, and $100 in Pennsylvania.

So these geographic variations could create serious equity problems. And I would just like your response, Mr. Richtman, as to what sorts of problems do you think this kind of disparity in possible premium costs and even possible benefit levels could pose to seniors?

Mr. RICHTMAN. Well, seniors, probably more than any other population, need predictability, and dependability. And they have that in Medicare as you just pointed out. The benefits follow them wherever they go, and the premiums follow them wherever they go.

And that is something that is very important to seniors. We have seen the upheaval that seniors have been subjected to when some of the HMOs over the last few years have shoved them out or raised their rates to the point where they had to leave.

And that is what we really worry about on behalf of our membership and other seniors; that that degree of predictability and dependability is maintained in the Medicare program.

And I wonder if I could respond to Congressman Norwood's point that he made. I thought it was to both Marilyn Moon and myself, and I will probably get into trouble having this much time to think about the answer.

But there are a lot of things that can be looked at in terms of paying for a benefit, a meaningful prescription drug benefit. First of all, I don't think it is accurate to say that seniors want all these things for free.

Most of the people that we have talked to, and in the surveys that we have done, and we have done a lot of polling on this issue, when it comes to prescription drugs, I think that seniors for the most part recognize that they are going to have to pay something.

Now, can they afford to pay double what their current Medicare Part B premium is? Probably not, and they probably would not avail themselves of the benefit. But they recognize that this is not going to be free to them, and I think that they accept that.

Mr. NORWOOD. What would they accept as a co-payment?

Mr. RICHTMAN. Some of the numbers that we have talked to our members about, and it seems to be a number that they can accept and they will be able to afford, are $25 and $35 a month.

Medicare Part B now is $54 and so that is adding on a considerable amount of money. But that is a number that seems to be a number that a lot of them do fine acceptable. In addition, I think you have to look at not just how you pay for it, but what it costs.

There are proposals out there that do deal with the cost of prescription drugs, and I am sure that you are all aware of some of them. We have just signed on to Senator McCain's proposal in the Senate.

I don't know that there is a bill in the house, but it would make it harder for the loopholes to be used now by the pharmaceutical companies in denying generics the ability to put those on the market. That saves money.

Then there is a whole other issue which I don't think I want to get into here, but of priorities, and the tax cut that was passed was a pretty big tax cut. It may be that some feel that a part of that could be delayed and some of those revenues could be used to finance a prescription drug benefit.

I think that Congressman Waxman said earlier today that a lot of candidates, and I know that this is true for Congress in the last election cycle, talked about prescription drugs.

I think almost all of them did, and there are going to be a lot of disappointed seniors around the country if nothing happens I feel.

Mr. DEMONTMOLLIN. Mr. Strickland, could I response to that just briefly?

Mr. BILIRAKIS. Do you have——

Mr. STRICKLAND. I guess, but I have not had a chance to ask a question.

Mr. BILIRAKIS. No, you haven't really.

Mr. DEMONTMOLLIN. I just wanted to respond to the $30 or $35 per month. It is important to understand that in the alternative.

Mr. BILIRAKIS. But that is in addition to what hey currently pay for Part B?

Mr. DEMONTMOLLIN. Absolutely. And what I am trying to suggest is that the current alternative to Medicare+Choice and the additional supplemental benefits that we provide is a Medigap policy.

If a senior was to buy currently the J-Medigap policy, which is the most rich in terms of a Medicare prescription benefit, it is a $3,000 max. And it is 50 percent coverage.

It would be necessary for a senior to spend $6,250 in order to get, because of the deductibles and the other things, the $3,000 in that benefit.

In Texas, that premium costs between $2,100 and $5,700 per year for that policy, and that would then make them responsible for cost sharing to the tune of $6,250 to get a $3,000 drug benefit.

Mr. STRICKLAND. Mr. Chairman, can I just make a statement?

Mr. BILIRAKIS. Please do.

Mr. STRICKLAND. I don't have much time.

Mr. BILIRAKIS. Don't worry about the time, but we do have to finish up some time or another.

Mr. STRICKLAND. Sure. I just want to make a statement, because Mr. Richtman touched on something that I think is relevant. When we went to fight the war on terrorism, the President said to the country and the country embraced the idea, that we would do whatever it took to protect us from terrorism.

Now, the polling that I have done in my last several campaigns quite frankly, have indicated that prescription drug coverage is if not at the top, near the top of the concern of the people in this country, and I think that we are talking about an economic issue here.

And we are also talking about a value issue, and some people don't want to here this. But I just wonder what we could have done with $1.3 trillion that we decided to use for a tax cut.

We could have had a prescription drug benefit, I think, and it is a matter of how we use our resources here, and that depends on our values.

Mr. BROWN. Will the gentleman yield for 1 second?

Mr. STRICKLAND. I will yield to my friend.

Mr. BROWN. I don't think we have ever been in wartime in this country's history when we have cut taxes on rich people, and you look at some of that effort and I don't think ever in our history have we done that.

I think that says something about our values as a country and what we ought to be doing in prescription drugs, and where we go.

Mr. STRICKLAND. Mr. Chairman, thank you for you graciously allowing me to exceed my time limit.

Mr. BILIRAKIS. Most of your time was exceeded not by you, but by the rest of us. But let's finish up though.

Mr. NORWOOD. Okay. I will try. Just to make a point. The reason that the taxes were cut is that the people who pay taxes demanded that they be cut, and to define rich is an interesting thing to do.

Frequently it means anybody with a job. So it was time that the people who paid the taxes had a little attention. Now, back to the prescription drug thing, and I have more questions than I can get out.

Mr. BILIRAKIS. Well, we have an opportunity to put it in writing.

Mr. NORWOOD. We are talking about Part B of 54 bucks today, and 20 percent per event co-pay. And you say that the people that you talked to are okay with paying some of it. Now, what we expect is, and I think that legitimately that $54 is going up to a hundred or better in the coming years.

We are looking at least at a $35 premium, and that is probably low for prescription drug benefit. They are okay so far at your townhall meetings. How much are they willing to pay per prescription co-pay?

Mr. RICHTMAN. Well, I really can't answer that, and in isolation, the $35——

Mr. NORWOOD. But if you know they are willing to pay, somebody has got to decide what are they willing to pay.

Mr. RICHTMAN. Well, we are working on that, and I don't have the answer to what the premium should be, the co-pay, the deductible, I don't have that. If I had the answer, I would tell you, but I don't.

Mr. NORWOOD. So you are concerned about this thing that I keep bringing up of 35 percent of our entire budget going to Medicare in the year of 2030, and you believe that Members of Congress ought to be concerned about that?

Mr. RICHTMAN. I do, and I think that some of the costs can be controlled. That's why I mentioned that there are a lot of proposals in the House and in the Senate to try to contain the cost of prescription drugs. Then it would not be that high of a percent.

Mr. NORWOOD. I asked you and Ms. Moon this question, that you made a blanket statement in your opening statement that we need to have prescription drug coverage. And it is a heck of a lot more complicated than just saying that we need to have a prescription drug program.

We all agree, too, that we want to, but unhappily we have the problem of figuring out how do you get that done. Steve, real quick, if I could. You have been with your company for how long?

Mr. DEMONTMOLLIN. For 10 years.

Mr. NORWOOD. For 10 years. Have you ever been with other managed care companies?

Mr. DEMONTMOLLIN. No, sir.

Mr. NORWOOD. So most of the statements that you make today are statements that you perceive for your company?

Mr. DEMONTMOLLIN. That's true, although the Speaker of the House in Florida, John Mills, was part of the DLC effort that I referred to, and I have been following the issue since 1987. But the answer to your question is yes.

Mr. NORWOOD. And so what I am after here is that we can't just take what you saw to mean that is what is happening in managed care in the United States, and what is happening in managed care in Tampa?

Mr. DEMONTMOLLIN. No, sir. I am here speaking on behalf of the American Association of Health Plans, which represents some 170 million members, and have been very active with them over these years. And I hopefully have some foundation upon which we can talk broadly.

Mr. NORWOOD. Just so you know that I am one of those people, and I said it earlier, that I think choice is probably the way to go, and managed care is one of the ways to have choice.

My problem is that giving people choice and there is no oversight. That's where I have been all these years, and we can't leave you to your own devices, because whether you are doing great in Tampa or not, there are places that aren't.

You made a statement——

Mr. BILIRAKIS. Well, they aren't doing, period.

Mr. DEMONTMOLLIN. Mr. Norwood, I wish I could have a plan in your district, and Mr. Strickland's district, and I think you would have a slightly different view of what we do in Medicare+Choice.

Mr. NORWOOD. You made a statement, and I am challenging it, too, that you do a better job in delivery of care to chronically ill.

Mr. DEMONTMOLLIN. Yes, sir.

Mr. NORWOOD. I don't question that with your company, because I don't know. But I question that in general.

Mr. DEMONTMOLLIN. I know, and we are going to provide you as soon as you asked that question with a report, or the studies upon which I base that remark.

Mr. NORWOOD. I know that I have got a study that says that you are wrong. You see, that is the problem. You can make a study say anything that you want it to say. I can make one say that you are the worst in the world for treating chronically ill patients.

Mr. DEMONTMOLLIN. My mama would be awfully embarrassed if I came up here and told you about a report that maybe somebody that wasn't credible had done, but you will have to decide that yourself.

Mr. NORWOOD. Well, I have. I have been there the last 7 years deciding the way that I felt about that.

Mr. BILIRAKIS. Again, we have the opportunity in writing. So we do have to finish up.

Mr. NORWOOD. Now, you asked or you wanted a level playing field between HMOs, managed care, and fee-for-service.

Mr. DEMONTMOLLIN. Yes, sir.

Mr. NORWOOD. And my understanding is that you want a hundred percent reimbursement, the same as fee-for-service. My understanding also is that what got you into this, and what started managed care, and why the taxpayers funded it through the earlier years in the seventies to get it off the ground is that you were supposed to be more efficient.

Why aren't you more efficient and why should we pay you the exact same thing as we do for fee-for-service? I don't understand why you aren't so efficient that it can't be less?

Mr. BILIRAKIS. Last question, and if it can't be answered briefly, Steve, feel free to answer it in writing, where you might have the opportunity to explain it in much more detail.

Mr. DEMONTMOLLIN. Thanks for that offer, Mr. Chairman. We have a very good explanation. I will be happy to provide it to Mr. Norwood and the committee.

Mr. BILIRAKIS. Let's do it that way. Is that all right with you?

Mr. NORWOOD. Oh, sure. I have no doubt that they have a good excuse.

Mr. BILIRAKIS. All right. Mr. Butler, we have not heard from you in a while, and I don't know whether you had anything that you wanted to add very briefly.

Mr. BUTLER. I would just sort of make two points really.

Mr. BILIRAKIS. Please do.

Mr. BUTLER. One is the cost comparisons between FEHBP and Medicare have to be looked at very carefully. You can very easily take the last 3 or 4 years of FEHBP and Medicare, during which time FEHBP by law and by administrative decision by the Clinton administration, had 44 new benefits added to it.

And at the same time as Congress recognized that it ratcheted it down too far in the Medicare side. So I think there is a pretty simple explanation.

If you look at what the Congressional Research Service has shown, however, is that over the last 14 years, and it looks at a much longer period, it shows the FEHBP, when adjusted for age, for all the other kinds of factors, have come in consistently below the Medicare. I think that is a very important point.

The second point I will just make in closing is that as I think as everybody said, nobody argues that there should not be a drug benefit for seniors, and that the benefits package should not be modernized. Nobody argues that.

The point is that you have to ask yourself I think why is it that you are in this situation of saying let's add a simple benefit, and not even catastrophic, but just a drug benefit to Medicare.

And why are you year after year having to do this? Maybe it has got something to do with the way in which Medicare is run and the relationship between Congress to Medicare. That is one of the most important lessons to learn from the FEHBP I think.

The FEHBP is not micromanaged by Congress, and that is a critical difference between the two systems as you all know, and you have drug benefits, and you have catastrophic, and you have new benefits every year. If you were in Medicare, you would be facing a totally different situation.

Mr. RICHTMAN. Mr. Chairman, can I make one sentence, one statement for the record. When you started the afternoon session, you talked about your commitment to seniors, and this is kind of a plug.

But we at the National Committee recognize your commitment to seniors, which is why we came down to Florida to your district a few years ago and gave you what I like to call a Coveted National Committee Friends of Seniors Award, and so we thank you for everything that you had done.

Mr. BILIRAKIS. Thank you very much for that, Max. I am glad that I allowed you to offer one sentence. Look it is a tough job, and—to not go into thing open-minded is—well, this doesn't mean that one side is more right than the other or anything of that nature. I don't mean that.

But to not go into these things open minded, I think is a real mistake. The easiest thing, Max, would be obviously to just leave Medicare as it now is, and just add to it, add prescription drugs to it if you will.

I mean, a lot of us feel strongly about Alzheimer's, for instance. I think that was probably one of my first causes, a real big cause when I came to the Congress. I found out in no time at all that I could not find a Member of Congress who knew anything at all about Alzheimer's.

There were not a lot of medical providers that knew much about Alzheimer's back in the early eighties. We grew hard calling it hardening of the arteries, and that sort of thing.

So we want to do the right thing, but I don't know. I mean, the easiest thing to do is to do exactly what Mr. Brown and the others want to do, roll back taxes if you will, and have Medicare as it now

is, and add a couple, but would that be the right thing to do? I doubt it.

Mr. BROWN. Was I that convincing today?

Mr. BILIRAKIS. You weren't convincing, but I take very seriously the comments made by people and the witnesses we have here. Thank you very much. I appreciate it, and again I appreciate your consideration and understanding because of the breaks that we have had.

[Whereupon, at 1:51 p.m., the subcommittee was adjourned.]

[Additional materal submitted for the record follows:]

PREPARED STATEMENT OF ADVANCED MEDICAL TECHNOLOGY ASSOCIATION

The Advanced Medical Technology Association (AdvaMed) is pleased to submit this comment for the record, in the important deliberations of the House Energy & Commerce Committee, Subcommittee on Medicare. AdvaMed is the world's largest association of medical technology manufacturers, with over 800 corporate members with operations worldwide. Our members manufacture technologies that are integral to nearly every aspect of healthcare, from diagnosis and treatment of disease, to managing disability and serious long-term illnesses.

Health care in the United States benefits from the most efficient, scientifically advanced therapies in the world, yet unfortunately these advances are not always available to the patients who need them most—America's seniors covered under the Medicare program. The Medicare fee-for-service program today continues to pose barriers to access for many of the advanced therapies available to privately insured patients. While private insurers rapidly incorporate and pay for new therapies as covered benefits, the basic Medicare program can delay appropriate payment for new services for up to five years, depending on the treatment and setting of care.

AdvaMed supports efforts to improve the existing Medicare coverage and payment processes, but we believe that comprehensive Medicare reform based on a competitive market-based system is necessary to ensure adequate and timely patient access to new technologies and therapies. Under a competitive market based system, innovative new technologies would be made available to patients based on the clinical value of the therapy and physician and patient demand.

MORE CHOICES THROUGH COMPETITIVE HEALTH PLANS

AdvaMed believes that it is essential to restructure Medicare to ensure that beneficiaries have access to high quality health care that provides prompt availability of the most innovative technologies without needless bureaucratic delays. We support the creation of a system that would provide Medicare beneficiaries with a broader choice of competing health plans.

The dynamic and creative forces of the marketplace and competition will lead to innovative alternatives and the individual options and choices that Medicare beneficiaries need. Private insurers in the U.S. are able to provide access to new technologies far more rapidly than Medicare, and are able to derive flexible solutions to address specific patient needs. Given clear choices, Medicare beneficiaries will chose the best quality and value offered in a competitive, patient-oriented health care system. The Centers for Medicare and Medicaid Service's (CMS's) role in such a system should be to administer Medicare's fee-for-service system, which should continue to be available to beneficiaries, managed by the current network of local contractors. Specific recommendations for long-term reform are as follows:

- Use of a framework of competing private sector plans to offer more competitive choices for Medicare beneficiaries.
- Development of a transparent process to determine minimum covered benefits and accountability for both private plans and fee-for-service contractors to provide such benefits in a consistent fashion.
- Flexibility for competing private plans to define benefits beyond a minimum benefit package, including coverage of experimental therapies. Competing private plans also should be able to establish market-based pricing for services, rather than government established fees.
- Full disclosure of coverage policies by both competing private plans and Medicare fee-for-service contractors.
- Implementation of competing market-based plans before any expansion of purchasing authority of the current Medicare fee-for-service program, so that market based plans are able to compete during their start-up phase.

- Retention and emphasis on local decisionmaking for the vast majority of coverage determinations in the fee-for-service program for new therapies and technologies, among a diverse range of contractors.

In conclusion, while the Medicare program faces the challenge of a rapidly growing aged population, it is presented with the opportunity of unprecedented advances in innovation. AdvaMed looks forward to working with key policymakers to help advance a Medicare agenda that fosters access to the most modern, efficient care possible, while still ensuring the highest quality.

Prepared Statement of The Alliance to Improve Medicare

The Alliance to Improve Medicare (AIM) is the only organization focused solely on fundamental, non-partisan modernization of the Medicare program to ensure more health care coverage choices, better benefits (including prescription drug benefits), and access to the latest in innovative medical practices, treatments and technologies through the Medicare system. AIM coalition members include organizations representing seniors, hospitals, small and large employers, insurance plans and providers, doctors, medical researchers and innovators, and others.

AIM recently approved the attached recommendations on expanding health care coverage choices for senior citizens who opt to participate in the Medicare+Choice program. AIM's recommendations call for strengthening the program by ensuring adequate payment levels for plans and providers, adopting different payment structures for different Medicare+Choice plan types, improving Medicare's regulatory framework, and increasing availability of Medicare beneficiary education materials.

Building and ensuring a strong Medicare+Choice program requires that beneficiaries have a range of options similar to those available to Members of Congress, federal employees and retirees, and million of working Americans under age 65 years of age who are covered by private plans. AIM believes the Federal Employee Health Benefit Program can serve as an example of flexible plan design and benefit structures to offer senior citizens nationwide a choice of health plans. The success of the FEHB program, and its continued availability in rural areas, should serve as model for efforts to strengthen and improve the Medicare+Choice program.

We applaud the Energy & Commerce Committee, and Health Subcommittee Chairman Michael Bilirakis, for their leadership on this issue and look forward to working together to strengthen and improve the Medicare program.

Expanding Health Care Coverage Choices for Seniors through Improving Medicare+Choice

AIM is a coalition of organizations representing seniors, doctors, hospitals, small and large businesses, medical researchers and innovators, insurance plans and providers and others dedicated to improving and strengthening Medicare for all Americans. AIM seeks to ensure that all senior citizens have more health care coverage choices, better benefits (including prescription drug coverage), and access to the latest in innovative medical practices and treatments. These recommendations address problems specifically confronting Medicare's managed care program, Medicare+Choice.

In the Balanced Budget Act of 1997, Congress took the important step of creating the Medicare+Choice program as a health insurance benefits option to Medicare beneficiaries. This option was designed to offer more choices for beneficiaries, and to provide beneficiaries with the ability to obtain additional benefits not covered under traditional Medicare, such as prescription drug benefits. Many beneficiaries who have selected Medicare+Choice plans are pleased with their ability to select these plans, and believe they have benefitted significantly from the comprehensive integrated benefits. Indeed, most Americans under age 65, especially those utilizing employer-provided health care, have managed care coverage choices similar to those offered in the Medicare+Choice program, and as more baby boomers become Medicare eligible, they will expect those same plan choices under Medicare.

AIM believes the principles of beneficiary choice inherent in the Medicare+Choice program can serve as a foundation for strengthening and improving the Medicare program. Building and ensuring a strong Medicare+Choice program requires that beneficiaries have an expanded range of options similar to those available to Members of Congress, federal employees and retirees, and millions of working Americans under 65 years of age who are covered by private plans. The Medicare+Choice program was envisioned to include a variety of health maintenance organizations, private fee-for-service plans, provider-sponsored organizations, and preferred provider networks but has been unable to attain that goal. Inadequate payments and excessive regulation of private sector plans and providers participating in

Medicare+Choice have seriously constrained the ability to expand coverage areas and have caused numerous plans to withdraw from coverage areas where reimbursement was inadequate to cover even the costs of basic care. As a result, millions of beneficiaries are at risk of losing their access to these plans and the additional benefits they have offered.

(1) **Ensure Adequate Payment Levels for Health Plans and Providers**—Currently, Medicare pays one set fee per month for each beneficiary enrolled in a Medicare+Choice plan based on a payment formula in the Balanced Budget Act of 1997 and regardless of the number of services the beneficiary may require. This payment formula has resulted in inadequate payment levels for Medicare+Choice plans in many parts of the country. For example, payments to health plans in many counties have been capped at two percent (three percent in 2001) annual increases over the past several years, despite growth rates in local health care costs that are as much as 8 to 12 percent. This has resulted in significant disparities between Medicare+Choice payments and local fee-for-service costs in some areas and contributed to many plans withdrawing from the program and reducing service areas. AIM supports an immediate increase in funding levels in order to save the program.

(2) **Adopt Different Payment Structures for Different Plan Types**—The current one-size-fits-all Medicare+Choice program payment structure sets many plans up for failure, especially in rural areas, and is unworkable if the program is to succeed and provide a variety of coverage options for Medicare beneficiaries nationwide. For example, building rural health plan and provider networks is difficult given less conducive health care market economics. Plans in many rural areas have difficulties negotiating payments because of higher-than-average Medicare volumes and because the cost of bearing full risk for a potentially small population is relatively high when plans cannot spread costs over a larger pool of insured individuals.

The Federal Employee Health Benefit Program (FEHBP) provides an example of flexible plan design and benefit structures. The FEHBP allows qualifying participants to choose from among a minimum of 10 plans nationwide, varying in plan type, benefit structure, and cost. FEHB program offerings currently include PPOs, HMOs, and indemnity plans which do not participate in the Medicare+Choice program because of inadequate payment levels caused by the program's inflexible payment structure.

AIM supports Medicare+Choice program improvements that will ensure a competitive market-based system of health plan options similar to that available to private sector Americans and federal employees and retirees. Congress and CMS should ensure that beneficiaries have a choice of plan types similar to those available to FEHBP participants. Allowing flexibility in the Medicare+Choice program payment structure to accommodate different plan types would encourage creativity in the market and could encourage more participation by a wider variety of plans.

(3) **Improve Medicare's Regulatory Framework**—AIM members believe that excessive regulation present in the Medicare+Choice program reduces innovation and consumer choice. AIM believes Medicare administrators must reduce excessive program complexity and bureaucracy caused by the more than 110,000 pages of federal rules, regulations, guidelines and directives. AIM supports the elimination of real fraud and abuse in Medicare but our members believe this can be achieved without relying on unnecessarily complex and heavy-handed regulation. Providers and plans must not be forced to divert resources from patient care in order to respond to ever-changing regulation.

CMS has had a fragmented approach to Medicare+Choice program oversight in the past. AIM members are pleased that CMS Administrator Scully has recognized this problem and begun to address it with the announcement of the new Center for Beneficiary Choices to focus on Medicare beneficiaries in private plans. This will allow for greater efficiencies and streamline requirements that now may be developed within different offices. We recognize and applaud the efforts of the Bush administration and Congress to begin to streamline many burdensome procedures and we encourage the administration and CMS to consider these additional actions:

- Publish Guidelines for Beneficiary Materials: End efforts to standardize written materials for Medicare beneficiaries. The current requirement for CMS approval of all documents and CMS's long term objective for standardizing many more communications is problematic. Health plans need to tailor their communications to their own programs. CMS should provide a checklist for plans of the information required to send to beneficiaries and develop marketing and communications guidelines.
- Create a Medicare Office of Technology and Innovation: Important new medical technologies and services must go through three sequential stages of Medicare decision-making—initial coverage, procurement code assignment, and payment level determination—before they are available to Medicare patients. This proc-

ess has suffered from a lack of coordination and created long delays in patient access to new technologies.

(4) **Increase Availability of Beneficiary Education Materials**—In a survey of Congressional Medicare caseworkers, AIM found that many beneficiaries are unaware of existing opportunities for assistance from such organizations as State Health Insurance Assistance Programs and other medical hotlines or simply lack access to opportunities such as the Internet (www.Medicare.gov) and the 800 Medicare hotline. Additionally, some beneficiaries currently have difficulty comparing benefits available through Medicare fee-for-service with benefits available through Medicare+Choice plans.

Medicare beneficiaries should have easy access to good information and benefit comparisons on the types of plans available. Beneficiaries need adequate, easy to understand information and clearly identified customer service representatives and insurance agents who can provide assistance by explaining coverage and benefit information and options. CMS can assist beneficiaries by recognizing that, because some beneficiaries desire more information on available plans, there is a need for a range of resources varying in scope and detail. The www.medicare.gov web site currently offers differing layers of information not elsewhere available to beneficiaries. These materials should be available to all beneficiaries, not just those with web access. CMS has begun to address this problem by increasing its ability to mail comparative information to beneficiaries who contact the Medicare hotline but who do not have Internet access.

Beneficiaries also need additional assistance understanding Medicare claims and appeals procedures for denial of payment for services. CMS should expand efforts to clearly explain claims and appeals procedures should be provided to beneficiaries and providers.

Prepared Statement of the American Psychiatric Association

Chairman Bilirakis, Representative Brown, and members of the Subcommittee on Health, this testimony for today's hearing on using the Federal Employees Health Benefit Program (FEHBP) as a possible model for Medicare reform is presented on behalf of the American Psychiatric Association (APA).

The American Psychiatric Association (APA) is the medical specialty association representing more than 38,000 psychiatric physicians nationwide. Our members are the frontline specialists in medical treatment of mental illness, and practice in all settings, including private practice, group practice, hospital-based services, nursing facilities, and community-based care, along with health programs under the auspices of the Federal Government such as the Public Health Service, the Indian Health Service, and the Department of Veterans' Affairs (VA health system). In addition, psychiatrists serve as academic faculty and practice in academic medical settings, and are at the forefront of research into the sources of and new treatments for mental illness.

Our statement will focus on issues related to mental disorders in the elderly population, including the scope of such disorders and particularly ongoing barriers to access to medically necessary treatment for mental illness in the Medicare program. We urge your Subcommittee in the strongest possible terms to address the substantial shortcomings in the Medicare program's coverage of treatment for mental illness in the elderly. Bluntly, if Congress does not eliminate long-standing statutory discrimination against Medicare patients seeking treatment for mental illness, we will face a serious crisis in the program.

APA therefore commends the Subcommittee for holding a hearing on the possible use of the FEHBP as a model for Medicare coverage of mental illness treatment, since, as we will discuss below, federal employees have since January 2001 enjoyed "parity" for mental health and substance abuse treatment. While some questions remain about the scope of the parity coverage, the FEHBP program shows that federal policymakers can and should eliminate current statutory discrimination against seniors and other Medicare beneficiaries seeking treatment for mental illness, including substance abuse disorders.

I. SCOPE OF MENTAL ILLNESS IN THE ELDERLY:

In 1999, then-U.S. Surgeon General David Satcher, M.D., Ph.D. released a landmark study on mental illness in this country. The Surgeon General's report is an extraordinary document that details the depth and breadth of mental illness in this country. According to Dr. Satcher, "mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer." The burden of mental illness

on patients and their families is considerable. The World Health Organization reports that mental illness (including suicide) ranks second only to heart disease in the burden of disease measured by "disability adjusted life year."

Some 35 million Americans are presently age 65 and older. America's elderly population will increase rapidly as our Baby Boom population—76 million strong—reach age 65 between 2010 and 2030. By 2030, older Americans will constitute 20 percent of the population, and our oldest old (85 and up) will comprise the most rapidly growing segment of all. The percentage of ethnic minority elderly will increase rapidly as well.

Mental disorders are highly prevalent in the elderly population. The Surgeon General's report on mental illness found that 20 percent of the population age 55 and older experience mental disorders that are not part of what should be considered as normal aging. Common disorders include Alzheimer's disease, depression, anxiety, cognitive impairment, drug misuse and abuse, and alcoholism.

The impact of mental illness on older adults is considerable. Prevalence in this population of mental disorders of all types is substantial. 8 to 20 percent of older adults in the community and up to 37 percent in primary care settings experience symptoms of depression, while as many as one in two new residents of nursing facilities are at risk of depression.

Older people have the highest rate of suicide in the country, and the risk of suicide increases with age. Americans age 85 years and up have a suicide rate of 65 per 100,000, twice the national average. Older white males, for example, are six times more likely to commit suicide than the rest of the population. There is a clear correlation of major depression and suicide: 60 to 75 percent of suicides of patients 75 and older have diagnosable depression. Put another way, untreated depression among the elderly substantially increases the risk of death by suicide.

Mental disorders of the aging are not, of course, limited to major depression with risk of suicide. The elderly suffer from a wide range of disorders including declines in cognitive functioning, Alzheimer's disease (affecting 8 to 15 percent of those over 65) and other dementias, anxiety disorders (affecting 11.4 percent of adults over 55), schizophrenia, bipolar disorder, and alcohol and substance use disorders. Some 3 to 9 percent of older adults can be characterized as heavy drinkers (12 to 21 drinks per week). While illicit drug use among this population is relatively low, there is substantial increased risk of improper use of prescription medication and side effects from polypharmacy.

II. ACCESS TO SPECIALTY MEDICAL CARE:

Given the demographic factors cited above, including the substantial increase in the numbers of the elderly between now and 2030 and the prevalence of mental disorders in this population, it is clear that there is a pressing need to ensure ready access to treatment for the Medicare population.

Despite the pressing need for delivery of mental health services to elderly patients, some studies show that as low as one-half of older adults acknowledging mental health problems actually receive treatment, and a relatively small percentage of those receive care from a specialized provider. At least half of all elderly patients receive their mental health care from primary care practitioners rather than specialty providers.

The proper assessment and treatment of mental disorders in late life is complicated by the prevalence of comorbid medical conditions and related disabilities in the elderly population. Thus, proper care of the elderly who seek treatment for mental illness requires specialized knowledge and clinical skills that enable the practitioner to assess complex interactions between medical illness, psychiatric disorders, the general processes of aging, together with the cultural, social, ethnic, and environmental factors that impact the patient.

Thanks to strong support from the National Institute of Mental Health, the field is increasingly able to rely on a rapidly growing body of scientific knowledge specific to mental disorders in the elderly. APA has responded directly to the needs of elderly patients by proposing and successfully enabling the establishment of geriatric psychiatry as a subspecialty. Current program requirements for residency education in geriatric psychiatry are extensive, and administered by the Accreditation Council for Graduate Medical Education. The training period is 12 months, and must occur following satisfactory completion of an ACGME-accredited residency in general psychiatry.

The educational program must include a wide range of clinical experience, including Geriatric Psychiatry Consultation (inpatient, outpatient, and emergency services); Long-Term Care, and Other Medical Specialty Experience (e.g., neurology, physical medicine and rehabilitation, geriatric medicine or geriatric family practice).

The specialty content of the ACGME requirements is very extensive, underscoring the complexity of treating mental disorders in the elderly population, and emphasize the critical role played by psychiatric physicians and particularly by geriatric psychiatrists in the proper diagnosis and treatment of mental illness among the elderly.

III. MEDICARE BARRIERS TO TREATMENT:

As noted, mental disorders are substantial in the Medicare elderly population but the Federal Government itself creates major barriers to treatment. These include the following:

Medicare Discriminatory 50 Percent Copayment:

Medicare law now requires patients to pay a 20 percent copayment for Part B services. However, the 20 percent copayment is not the standard for outpatient psychotherapy services. For these services, Section 1833(c) of the Social Security Act requires patients to pay an effective discriminatory copayment of 50 percent.

This bears repeating: If a Medicare patient has an office visit to an endocrinologist for treatment for diabetes, or an oncologist for cancer treatment, or a cardiologist for heart disease, or an internist for the flu, the copayment is 20 percent. But if a Medicare patient has an office visit to a psychiatrist or other physician for treatment for major depression, bipolar disorder, schizophrenia, or any other illness diagnosed as a mental illness, the copayment for the outpatient visit for treatment of the mental illness is 50 percent. The same discriminatory copayment is applied to qualified services by a clinical psychologist or clinical social worker. This is quite simply discrimination.

190-Day Lifetime Reserve:

In a similar vein, Medicare law limits to 190 days in a patient's lifetime the number of covered days to which beneficiaries are entitled if they seek treatment in a freestanding public or private psychiatric hospital. The 190-day lifetime reserve does not apply to hospital care for non-psychiatric illness in general hospitals, nor does it apply to treatment received for psychiatric illness in psychiatric wards in general hospitals. Yet if patients seek treatment in hospitals that specialize in the diagnosis and care of patients with mental illness, they are covered only for 190 days in their lifetime. Again, this is statutory discrimination against patients with a specific diagnosis receiving treatment in a particular facility.

Intermediate Services:

Medicare coverage lags well behind private sector development of a range of psychiatric services that are less intensive than hospital-level services but more intensive than outpatient services. These include, for example, crisis residential programs and mental illness residential treatment programs, group homes, residential detoxification programs, residential centers for substance abuse treatment, psychiatric rehabilitation, intensive case management, day treatment, ambulatory detoxification, and so on. The currently available "intermediate" level of service, partial hospitalization, is effectively on hold due to shortcomings in the statutory authorization of the program.

QMB Discriminatory Payment Reduction:

A related problem is the doubly discriminatory treatment of low-income patients who are eligible for both Medicare and Medicaid. Under current law, state Medicaid programs are required to make Medicare cost-sharing assistance to such patients, known as "QMBs" (for qualified Medicare beneficiaries). In brief, states are required to buy into the Medicare program for QMBs (who are by definition poor individuals), paying the Part A and Part B premiums, along with deductibles and copayments. In 1992, the then-HCFA Medicaid Director issued a directive that states were no longer obligated to pay a portion of the payment for psychiatric outpatient services subject to the underlying discriminatory Medicare 50 percent copayment requirement, since that portion was held not to be an incurred beneficiary expense. That finding put HCFA in the position of saying that for Medicare purposes, the 50 percent copayment was an incurred beneficiary expense, but for Medicaid—and QMB—purposes, a portion of the copayment was not. The direct result of the finding was that most states stopped paying for the full amount of the copayment, creating an enforced substantial "discount" for services provided to one group of Medicare patients, and a significant disincentive to treat such patients along with the discount.

Mr. Chairman, taken together, the examples cited above spotlight significant disincentives inherent in federal programs funding delivery of services to the elderly. The examples also underscore the dramatic need for sweeping changes to Medicare and other federal programs to eliminate statutory discrimination against patients

seeking treatment for mental disorders. The underlying discrimination is compounded by problems such as regulatory hassles and the extraordinarily unwise 5.4 percent reduction in the Medicare update.

Regardless of the specific mental disorder diagnosed, it is absolutely clear that mental illness in the Medicare population causes substantial hardships, both economically and in terms of the consequences of the illness itself. As Dr. Satcher put it in his landmark report, "mental illnesses exact a staggering toll on millions of individuals, as well as on their families and communities and our Nation as a whole."

Yet there is abundant good news in our ability to effectively and accurately diagnose and treat mental illnesses. Mental illness treatment works. Unfortunately, today, a majority of Medicare patients who need treatment for mental illness do not seek it or do not get it from specialty providers. Much of this is due to statutory discrimination that compels patients seeking treatment for psychiatric illness to pay more out of their own pockets.

Congress would be outraged and rightly so if federal law forced a Medicare cancer patient to pay half the cost of his or her outpatient treatment, or a diabetic 50 cents of every dollar charged by his or her endocrinologist. So why is it reasonable to tell the 75-year-old that she must pay half the cost of treatment for major depression? Why should a schizophrenic patient incur a 20 percent copayment for visiting his internist, but be forced to pay a 50 percent copayment for visiting a psychiatrist for the treatment of his schizophrenia? Why also should patients not have access to the full range of services now available to treat their disorders?

IV. FEHBP AND OTHER SOLUTIONS:

APA has always urged Congress to end these discriminatory inconsistencies in Medicare coverage as part of any major effort to overhaul the Medicare program. Certainly, as the House moves forward this year with a possible Medicare overhaul, repeal of the 50 percent copayment requirement and other discriminatory features of Medicare's coverage of mental illness should be addressed.

As noted, the FEHBP offers a possible model for the road to travel to achieve nondiscriminatory coverage of treatment of mental illness in the Medicare program. Prior to 1999, the Office of Personnel Management, via the annual FEHBP "call letter" process, had negotiated enhanced mental health coverage in the program. For example, OPM successfully eliminated lifetime and annual maximums for mental health care, moved gradually away from contractual day and visit limits, and covered medical visits and testing to monitor drug treatments for mental conditions under the same terms as pharmaceutical disease management.

Following the White House Conference on Mental Health in June 1999, President Clinton announced that the Federal Government would implement mental health parity in the FEHBP program. Following the issuance of several policy guidelines (June 1999, April 2000, and July 2000), the parity requirements were implemented effective January 1, 2001. In a memorandum dated July 13, 2000, then-OPM Director Janice LaChance noted that "Parity in the FEHBP Program means that coverage for mental health, substance abuse, medical, surgical, and hospital services will be identical with regard to traditional medical care deductibles, coinsurance, copays, and day and visit limitations. Historically, health plans have applied higher patient cost sharing and shorter day and visit limitations to mental health and substance abuse services than they did to services for physical illness or injury. Beginning January 1, 2001, this practice will stop when patients use network providers and comply with authorized treatment plans."

Indications are that, to-date, parity implementation is effective, has been smooth, and has resulted in little if any dislocations. In testimony before the Senate Committee on Health, Education, Labor, and Pensions (July, 2001), William E. Flynn, III, then-Associate Director for Retirement and Insurance at OPM, reported that "Early indications are that parity implementation is going well. In the few cases where coverage or access problems have arisen, we were able to address them quickly to ensure that federal enrollees are receiving the benefits to which they are entitled under their plans."

In addition to the APA support for the moral imperative of ending discriminatory coverage of treatment of mental illness, the cost data on FEHBP parity is also favorable, showing clearly that parity is achievable for modest costs. According to Mr. Flynn's 2001 testimony, "parity implementation has resulted in an... aggregate (premium) program increase of 1.3 percent for 2001. In terms of the impact on individuals, those with a self-only enrollment pay $0.46 for parity every two weeks, while family enrollees pay $1.02"

APA has long advocated for and supported legislation such as H.R. 599 in the current Congress that would eliminate Medicare's historic discriminatory 50 percent copayment requirement for outpatient mental health services. The legislation would simply require Medicare patients receiving such services to pay the same 20 percent copayment they pay for all other medical care today. Based on the FEHBP experiment, we certainly believe that parity is achievable in the Medicare program. Can anyone suggest the modest costs—25 cents per week by enrollees and 1.3 percent aggregate premium effect—are not worth the elimination of long-standing discrimination against Medicare patients seeking treatment for mental illness?

V. CONCLUSION:

Mr. Chairman and members of the Subcommittee, the American Psychiatric Association joins in saluting you for your foresight in holding this important hearing on options to overhaul the Medicare program. The problems are particularly acute for elderly patients seeking treatment for mental disorders, who must cope not only with the need to seek care, but also with the unfortunate fact that they are required to pay more for such care when they are able to seek it. Whether through consideration of an FEHBP-style benefit option or adoption of H.R. 599, we urge you to end the discrimination against our Medicare patients when they seek medically necessary care for mental illness.

Thank you.

RESPONSE FOR THE RECORD OF STUART M. BUTLER, VICE PRESIDENT FOR DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION

Question #1: Does CMS publish a guide to the Medicare plan that is similar to the FEHBP guide? How would such a guide be helpful for beneficiaries? Is the information on provider quality and plan responsiveness helpful for elderly beneficiaries in the FEHBP program? Some have stated that beneficiaries might not be able to evaluate plan comparison information. Do you believe that beneficiaries find the information in these guides confusing and/or overwhelming?

A: Yes. CMS publishes a guide for Medicare beneficiaries entitled *Medicare and You.* The CMS also has a web site. The Committee can examine relevant GAO reports and recent testimony before the House Subcommittee on Health of the Ways and Means Committee on the CMS products to get a flavor of the difficulties facing Medicare beneficiaries. In short, these products are neither user-friendly nor, in the web version, easy to access or understand for comparative purposes. In his February 28, 2001 testimony before the House Ways and Means Subcommittee on Health, health care economist Walton Francis, an expert on FEHBP and the Medicare program, observed:

> "The version (of *Medicare and You 2001*) for DC, Delaware, Maryland and Virginia has about 85 numbered pages of information. Of these, 17 pages provide plan specific information on Medicare+Choice plans and the remaining pages other information about Medicare (Telephone numbers take up 7 pages, even more than in 1999). The 17 printed pages of information, however, provide only 9 specific facts about each of the 13 covered plans: company name, plan name, telephone number, service area, premium, whether or not any prescription drug coverage, percent rating their care highly, percent of women receiving mammograms, and percent dis-enrollment. All of this information for all of these plans could have fit on one typewritten page. In sum, HCFA uses 85 pages to produce one page of plan comparison information." [1]

For enrollees in the FEHBP program, there is superior clarity in the presentation of comparative health information from both government and private sector sources. OPM annually publishes a *Guide* to FEHBP plans. This is a simple, detailed and plain English comparison of plans, rates and benefits. The 2001 edition of the *Guide* was 55 pages in length.

Beyond the OPM *Guide,* prominent private sector organizations publish comparative information on plans and guides to FEHBP plans for active employees and retirees. Each year, the National Association of Retired Federal Employees (NARFE) publishes *Federal Health Benefits and Open Season Guide,* which is oriented specifically to federal retirees and rates plans on benefit packages. The Washington Consumers Checkbook publishes *Checkbook's Guide to Health Insurance Plans for Federal Plans for Federal Employees.* These guides are written in plain English. They provide excellent comparative information on price, benefits and service.

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[1] Walton J. Francis, Hearing on Medicare Reform, testimony before the Subcommittee on Health of the House Committee on Ways and Means, February 28, 2001, p. 4.

In the case of the *Checkbook* guide, there are detailed plan comparisons and ratings on the quality of services and are based on annual surveys of all plan enrollees, including retirees. In the FEHBP, retirees make up 40 percent of all enrollees in the FEHBP program. The ratings cover the following topics: the overall quality of the health care provided by the plan, and access to personal physicians and specialists; the percentage of complaints; the ability to get needed care; the ability to get care quickly; how well doctors communicate with beneficiaries; the courtesy and helpfulness of the doctors' office staff; the plan's claims processing; the performance in getting referrals to specialists; the ability to get a personal doctor one is "happy with"; the ability to deliver the care the beneficiary or the beneficiary's doctor believed was necessary; the ability to get approval for care "promptly; getting advice or help from the doctor's office when one calls; enrollees impression of the plan's customer service; getting an appointment as soon as needed for illness or injury; getting explanations one could understand from one's doctors, getting enough time with doctors.

This information is clearly helpful to beneficiaries. The *Checkbook* ratings, particularly on quality and service (including the responsiveness of physicians and specialists, or the ease in dealing or communicating with physicians and specialists) are particularly helpful to elderly beneficiaries. There is nothing confusing about percentage rankings of plans' performance on the very relevant topics of patient care covered in the survey. In 2001, for example, federal retirees residing in Idaho and interested in the Idaho Group Health Cooperative, an HMO, would be able to find out that 93 percent had a positive assessment of how well that plan's doctors communicated with patients.

Beyond the published guides, the Committee should also be aware of the growth of FEHBP comparative information on the Internet. According to *PlanSmartChoice,* a company providing comparative Internet information to FEHBP, enrollees reported to OPM that users of the web site registered satisfaction levels of 90 percent or more.[2] The report to OPM also included samples of positive responses from retirees, negative comments, and suggestions for improvement of the web site.[3] Another prominent on line site in the FEHBP is www.guidetohealthplans.org There is no reason why 21st retirees, including the first wave of the 77 million Baby Boom generation, should not be able to take advantage of rapidly advancing information technology for periodic health plan comparisons.

Question #2: Is it possible to have multiple plans in some of the more rural areas of the country?

A: Yes. In the FEHBP, every enrollee, rural or urban, has a multiple choice of health plans. Today, there are 11 health plan options available to all enrollees nationwide. In 2001, FEHBP had 15 health plan options available to all enrollees. Normally, these national plans are "fee for service" or preferred provider organizations. The FEHBP rules governing the participation of HMOs are very different. HMOs participate at the state, and the number of participating HMOs, which today cover roughly 40 percent of all FEHBP enrollees, varies from year to year. There is no reason, of course, why a reform of Medicare could not establish a similar structure for plan options for future Medicare enrollees.

Question #3. Your testimony states that OPM prescribes "reasonable minimal standards" for plans. Can you explain how those standards are developed? Do you believe that a separate Medicare Board could work in a similar fashion?

A: Under Section 8902 of Title 5 of the U.S. Code, OPM—may prescribe reasonable minimum standards' for health benefits plans and for carriers. As the Congressional Research Service (CRS) has observed in its comprehensive 1989 analysis of the FEHBP, the legislative language authorizing the FEHBP gave OPM "broad powers" to administer the FEHBP, and OPM has thus had "wide latitude to institute changes it felt were needed..."[4] Under Section 890.201 of *The Code of Federal Regulations*,[5] OPM has thus set forth rules to admit and negotiate with health plans that comply with the provisions of Chapter 89 as amended. Under OPM rules, competing plans have to accept enrollment of employees and retirees without discriminating against them on such grounds as age, race, sex or health status; provide

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[2] *PlanSmartChoice: Fall 2000 Open Enrollment: A Report to the Office of Personnel Management,* prepared by PlanSmart Choice Inc., Research Triangle Park, North Carolina, June 25, 2001, p. 1.

[3] PlanSmart Choice, *op. cit.*, pp. ii-vi

[4] *The Federal Employees Health Benefits Program: Possible Strategies for Reform:* A Report prepared by the Congressional research Service for the Committee on Post Office and Civil Service, US. House of Representatives, 101st Cong., 1st Sess. (Committee Print 101-5), May 24, 1989, p. 238.

[5] *Code of Federal Regulations,* Title 5, Volume 2, Parts 700 to 1199, revised as of January 1, 2001, pp.410-412.

health benefits to enrollees, "wherever they may be"; provide for guaranteed renewability of coverage for enrollees; provide enrollees an identification card; provide a standard rate structure for individuals and family coverage; maintain statistical records for the plan covering federal employees separate from other insurance business; provide for "a special reserve fund" for the plans operations and reinvest any fund income into the fund; provide for continued enrollment of persons during the contract period; provide for coverage without reference to pre-existing physical or mental conditions; and provide for enrollment without a waiting period for a covered persons.

Under its statutory authority, OPM is to contract with those plans that are licensed in the states; that are reinsured with other companies which elect to participate under an "equitable formula"; that offer detailed statements of benefits with definitions of limitations and exclusions that OPM considers "necessary or desirable"; that charge rates that "reasonably and equitably" reflect the costs of the benefits; and that agree to provide benefits or services to persons entitled, as OPM determines, under the terms of its contract. OPM is also authorized to levy a surcharge on plans of up to 3 percent of premiums to establish a contingency reserve fund for the payment of unforeseen claims.

Under Section 8902 of Title 5, the terms of any contract between OPM and a competing plan pre-empt any state or local law governing health insurance or health plans.

There is no reason why a Medicare Board, or similar agency, could not perform the very same functions as OPM in a reformed Medicare program. The Board could be an independent body within the executive branch, like OPM, or it could be a special agency within HHS.

Question #4: How does the current Medicare program make it more difficult for beneficiaries to have reasonable access to cutting edge treatments?

A: Medicare's current structural obstacles delay patients access to cutting edge medical services and technologies that are routinely available to patients in the private sector. There are many particular examples. In a general study of this question for the Advanced Medical Technology Association, the Lewin Group, a major Virginia-based econometrics firm that models health policy changes, found that it takes anywhere between 15 months to five years for a medical technology to be available to Medicare patients.[6] The reason for this is the complicated CMS process for making coverage decisions, which can take anywhere from 1 to 5 years, then procedural coding for the new the technology, which can last anywhere from 15 to 27 months, and the process for setting payment, which can take 24 months or more.[7]

Beyond the internal CMS process for making coverage, coding and payment decisions, there is also the manner in which CMS prices medical technologies or cutting edge treatments. Medicare uses an administrative pricing system, which may have little or nothing to do with the actual market price of a treatment or medical technology. While the technology or treatment may be technically covered by the Medicare program, a Medicare patient has to find a doctor or provider willing to offer it at Medicare's often artificially low price. This also can make it more difficult for Medicare patients to get access.

Congress has tried, with limited success, to improve Medicare patient access to cutting edge technologies and treatments with the enactment of the Benefits Improvement and Protection Act of 2000.

Question #5: Can you expand slightly on the FEHBP trust fund? Specifically, do you believe that it would be important to have a similar trust fund to monitor the solvency, or financial stability of any modernized Medicare program?

A: All premium contributions, including the premium payments from federal employees and federal retirees, as well as federal agency contributions, are deposited in the Federal Employee Health Benefits Trust Fund.

For federal retirees, OPM administers their enrollment, provides for an automatic deduction of their portion of the premium from their monthly federal retirement checks, adds the applicable government contribution and deposits that money in the FEHBP Trust Fund. For active federal employees, their employing agency withholds the employees' contribution toward the premium from their paychecks, adds the government contribution, and that amount is credited to the FEHBP Trust Fund. Congress, of course, each year appropriates the projected amounts for the FEHBP Trust fund for federal retirees, as part of the Treasury Postal Appropriations process. For

[6] Advanced Medical Technology Association, "Medicare Overview: Improving patient Access to Innovative Technology, presented in 2001-2002 *Medical Technology: An Agenda for Innovation and Patient Access* (Washington DC, 2002).

[7] *Ibid.*

federal employees, the agency funds for FEHBP payment, like salaries and expenses, are included in routine federal agency appropriations.

The FEHBP trust fund is administered by OPM, but it is formally a part of the United States Treasury. The Secretary of the Treasury, in consultation with OPM, has the legal authority to invest the assets of the trust fund in federal government securities, and interest income from these government securities is also credited to the trust fund. During the contract year, payments to health insurance plans or carriers are made directly from the U.S. Treasury and those payments are charged to the FEHBP Trust Fund. OPM's administrative expenses are also charged to the FEHBP Trust Fund.

In contrast to the Medicare program, with the Hospital Insurance (HI) and the Supplemental Medical Insurance (SMI) trust funds, financed on entirely different bases, the FEHBP Trust Fund is comparatively simple. In the FEHBP, both the government contribution and the beneficiary premium payments for all medical services are combined, and there is no open-ended draw on general revenues, as there is today in the SMI portion of Medicare. The Medicare "solvency" debate often revolves around how one measures the fiscal health of the Medicare program. In my view, the issue is not confined to the health of the Hospital Insurance trust fund. Rather, the problem is the growing gap between the projected benefit costs and the revenues dedicated to the Medicare program.

Premium Income and disbursements in the FEHBP Trust Fund are easily tracked. The income for the Fund itself is routinely dependent upon congressional action. If, for any reason, there is a need for a supplemental appropriation for the FEHBP trust fund, then Congress can easily provide for it. In this respect, the FEHBP Trust fund model is superior as a mechanism for monitoring the solvency and ensuring the financial stability of a modernized Medicare system.

RESPONSES FOR THE RECORD OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

QUESTIONS OF CHAIRMAN MICHAEL BILIRAKIS

Question 1. Are any of your members involved in Medicare+Choice plans? I understand that Medicare+Choice is not located in all areas: however, do you know if beneficiaries that live in areas with Medicare+Choice have the same level of out-of-pocket costs as those seniors not enrolled in a Medicare+Choice plan in the same area?

Answer. Yes, some of our members are involved in Medicare+Choice plans. We do not know if persons in Medicare+Choice plans in an area have the same level of out of pocket costs as those not in such plans. We know that House hearing have revealed that indeed in some areas, out of pocket costs in Medicare+Choice does exceed those in traditional Medicare.

We also know that beneficiaries in Medicare+Choice often complain that their out of pocket costs are constantly increasing. "Extra" benefits are often decreasing, particularly prescription drug coverage. Many beneficiaries say they joined the plans because they offered some prescription drug coverage, but the coverage has been stopped altogether or greatly decreased.

Question 2. You state that premiums have escalated steadily in FEHBP over the last five years. Do you have any data to support this notion? If so, do you know how much the increase has been? Also, are you aware of any access problems for FEHBP participants in gaining access to cutting edge medical care?

Answer. The statement that premiums have increased steadily over the last five years is from the Congressional Research Services Report for Congress, Health Insurance for Federal Employees and Retirees, January 2, 2002, by Carolyn L. Merck. She states in the summary that FEHBP premiums in 2002 will be about 13.3% higher than in 2001. She goes on to say "On average, annual premiums increases have exceeded 9% since 1998 bringing cumulative increases since then to nearly 50%." In only 5 years premiums have doubled.

In 2001, total annual FEHBP premiums for self-only policies averaged about $3,100. This is not a good model for Medicare. Most seniors, with annual incomes around $15,000 cannot afford this type of premium. Seniors pay $600.00 in premiums for Medicare.

That report also stated FEHBP covers only 8.6 million people. Medicare covers 40 million so the programs may be incomparable based on size.

No problems of access to technology have been reported to the NCPSSM.

QUESTIONS FROM CONGRESSMEN DINGELL AND BROWN

Question. You were asked in the hearing to specifically state what benefit seniors support in terms of how much of a premium and cost sharing they would be willing to pay and still find a drug benefit attractive and affordable. While you mentioned a $25-$35 premium, could you elaborate on the other considerations in a drug benefit? Do you believe that either the President's Budget or the House Budget Resolution provides adequate funding for a Medicare prescription drug benefit?

Answer: Our members have told us the same information that is reported in polls, surveys and focus groups: seniors want a prescription drug benefit that is affordable for them and is comprehensive. Seniors, and their children, do the "kitchen table test." They will sit down with paper and pencil and calculate the premium, deductible, cap, and copay. Based on this they will decide if the benefit is affordable and therefore, if they will enroll. For these reasons we too must look at the benefit as a whole to determine what is affordable. A monthly premium of $20.00 doesn't make a benefit affordable if the plan has a $650.00 deducible.

The President's budget allocation of $190 billion for Medicare reform and prescription drugs is not enough to fund a benefit that is affordable and comprehensive. Even the $350 billion the House included in their budget is not enough. During the hearing many mentioned the advantages of the FEHBP program. The main advantage of the FEHBP program and one that needs to be adopted immediately for seniors is that it does include prescription drugs. Congress has reported that a FEHBP type prescription drug benefit for seniors would cost $750 billion over 10 years. Therefore, this is the amount that needs to be allocated for prescription drugs alone. Seniors expect a benefit equal to FEHBP, this is what they got during their working lives and this is what retiree health plans offer. Seniors expect about a 20% copay or cost sharing.

RESPONSES FOR THE RECORD OF STEPHEN J. DEMONTMOLLIN, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, AVMED HEALTH PLAN

Question 1. Why was AvMed forced to leave the Tampa area? Are you interested in coming back into the Tampa area to serve Medicare beneficiaries? If so, what steps could Congress take to ensure your re-entrance and expansion in Florida? If I were able to help make these adjustments law, could you commit that AvMed would be willing to come back into the Tampa area?

Response 1. AvMed is Florida's oldest and largest not for profit HMO and its mission includes the desire to serve the Medicare and Medicaid populations in Florida. AvMed currently serves fewer than 30,000 Medicare members down from more than 75,000 beneficiaries at the time of the passage of the Balanced Budget Act. AvMed would very much like to return to the Tampa area as a Medicare+Choice organization and would do so if adequate and stable funding were made available in the program. Current law projects an increase of only 2% for the Tampa area for M+C beneficiaries in 2003 despite broad agreement that the actual increase in medical costs for the area is approximately 11% and prescription drug costs are rising at an even higher rate. The Federal Employees Health Benefit Program is projecting premium increases of at least 13% and the CALPERS rates were recently renegotiated at an increase of more than 25%. It is hard for the Medicare beneficiaries who want a choice in their health plan to understand why they are being treated in such a disparate fashion. AvMed has sustained losses of some $60 million since 1997 related directly to the draconian reductions in M+C funding and is now struggling with meeting the statutory surplus requirements of the Florida Department of Insurance.

In the Balanced Budget Act of 1997, Congress reduced the projected rate of growth of revenues to hospitals contracting with HCFA over five years by more than 20 percent and reduced the projected rate of growth of payments to Medicare HMO risk contractors by some 17 percent over the same period. The hospitals which were facing the reductions in future revenue rate growth, immediately began discussions with HMOs to renegotiate contracts to make up some of the projected shortfall. In fact, over 60% of the AvMed hospital network insisted on rate renegotiations regardless of where the hospitals were in the contracting cycle. That is, most hospital contracts are terminable with sixty days notice and 60% of the hospital network threatened to terminate the agreements unless new rates were put in place. From 1997 to 1999, three hospitals of one system in North Dade county insisted on rate increases of 57%, 49% and 26% respectively. A Tampa hospital is currently demanding a 23% increase in its inpatient rates for 2003. Accordingly, Medicare HMOs experience the "double whammy" of reductions in their own revenue growth projections as well as the likelihood of higher provider contract rates.

Specifically, AvMed lost $2,415,000 in Hillsborough County in 1998 and $1,948,000 in 1999 before having to institute significant cost sharing to its members through premiums and benefit reductions to reduce the loss to $444,000 in 2000. AvMed lost $961,000 in 2001 and was projected to lose $79.57 per member per month in 2002. Confronted with the certainty of significant losses in 2002, AvMed had no choice but to withdraw from the County. Mr. Chairman, we very much want to serve the seniors in southwest Florida but can no longer continue to incur such tremendous losses. We are a Florida not for profit corporation but unless we have an adequate net margin, we can not achieve our mission.

Despite the tremendous losses generated by the Balanced Budget Act, AvMed is committed to doing everything in its power to remain in the Medicare+Choice program and to continue serving seniors in Florida. AvMed is very hopeful that increased and stable funding will be achieved and that it will be able to re-enter the Tampa area market. Certainly, the 200,000 seniors in the Coalition for Medicare Choices have made it clear that Medicare beneficiaries want choices in selection of their health care plan.

Question 2. President Bush has proposed a 6.5% payment increase in 2003 for M+C plans that have been limited to the minimum payment update in recent years. Do you believe that this payment increase will encourage are hopefully guarantee that plans will remain in the Medicare+Choice program? Are there other issues that need to be addressed for plans to increase participation in the program?

Response 2. Yes, President Bush's proposed 6.5% payment increase would provide an immediate and necessary infusion of funds into health plans serving counties that have received only minimum payment updates since 1997. Keep in mind that between 1998 and 2002, payment in these counties increased only 11.5 percent overall, compared to increases in fee-for-service spending of over 21 percent over the same time frame and annual medical inflation of between 9 and 10 percent. The Administration's 6.5% increase is an extremely important first step for those counties that have consistently received only the minimum update. However, since those counties have lagged so far behind actual real-world increases in medical spending, a multiple-year fix will be needed to help plans continue to participate in the Medicare+Choice program. Plans need predictability and sustainability in subsequent years to ensure continued participation.

Question 3. What role do Medicare+Choice plans play in serving low-income beneficiaries? Can you address the argument by opponents of Medicare+Choice that plans pick the healthier beneficiaries and leave the sicker beneficiaries to fee-for-service?

Response 3. Medicare+Choice plans play an important role in providing health coverage to beneficiaries who are financially vulnerable. Many low-income beneficiaries rely heavily on Medicare+Choice plans to provide comprehensive coverage not available under the Medicare fee-for-service program. The American Association of Health Plans (AAHP) has conducted research on this issue, focusing specifically on beneficiaries who have supplemental coverage (i.e., coverage for services not covered by the Medicare fee-for-service program) that is not subsidized (i.e., not paid for by Medicaid or a prior employer).

According to AAHP's research, among unsubsidized Medicare beneficiaries in the urban West who had supplemental coverage and who had annual incomes below the federal poverty level, 76 percent had selected Medicare HMOs. *This finding shows that Medicare HMOs serve many beneficiaries who have modest incomes, but do not qualify for Medicaid assistance.* AAHP's research also indicates that, among beneficiaries in the urban Northeast, 41 percent of beneficiaries who had *unsubsidized* supplemental coverage were enrolled in Medicare HMOs while only 5 percent of beneficiaries who had *subsidized* supplemental coverage were enrolled in Medicare HMOs. *This finding demonstrates that Medicare HMOs serve many beneficiaries who do not receive supplemental health coverage that is paid for by Medicaid or prior employers.*

Another key finding of AAHP's research is that among Medicare beneficiaries who receive unsubsidized supplemental coverage for prescription drugs, 54 percent obtained such coverage through Medicare HMOs. *This finding highlights the important role Medicare+Choice plans play in providing prescription drug coverage to beneficiaries who do not receive such coverage through Medicaid or a prior employer.* In addition, the BlueCross BlueShield Association (BCBSA) recently released a study showing that low-income Medicare beneficiaries, as well as African-Americans and Hispanics, are more likely to enroll in the Medicare+Choice program than other beneficiaries.

This study focuses specifically on the choices made by Medicare beneficiaries who live in areas where Medicare+Choice plans are available and who do not receive Medicaid coverage or employer-sponsored coverage. Noting that 13 million Medicare

beneficiaries meet these criteria, the study identifies these beneficiaries as "active choosers." The following findings were reported for these beneficiaries:

- in southern California, 78 percent of "active choosers" with incomes between $10,000 and $20,000 are enrolled in Medicare+Choice plans;
- in Philadelphia, 67 percent of "active choosers" with incomes between $10,000 and $20,000 are enrolled in Medicare+Choice plans;
- in southern Florida, 51 percent of "active choosers" with incomes between $10,000 and $20,000 are enrolled in Medicare+Choice plans;
- nationwide, 40 percent of "active choosers" with incomes between $10,000 and $20,000 are enrolled in Medicare+Choice plans; and
- nationwide, 56.1 percent of Hispanic "active choosers" and 40.3 percent of African-American "active choosers" are enrolled in Medicare+Choice plans.

This study also concludes that if the Medicare+Choice program was no longer available, a total of 1.5 million current Medicare+Choice enrollees would choose to go without supplemental coverage. Indicating that 42 percent of African-Americans currently enrolled in Medicare+Choice plans would rely on the Medicare fee-for-service program only (with no supplemental coverage), the study cautions that "ending access to Medicare+Choice would have a disproportionate effect on African-American beneficiaries."

It is not true, as some claim, that Medicare+Choice plans attract only healthy beneficiaries. This charged is based largely on a report the General Accounting Office (GAO) issued in August 2000 claiming that Medicare+Choice plans attract a disproportionate share of healthier and less expensive beneficiaries relative to fee-for-service (FFS) Medicare. In reaching this conclusion, the GAO used a flawed methodology that examined beneficiaries' costs based on their prior use of services in the FFS program to estimate beneficiaries' costs once enrolled in Medicare+Choice plans.

AAHP has long been concerned about this approach, since it includes no information about beneficiaries' use of services once they are enrolled in Medicare+Choice plans. As a result, the measure used in GAO's methodology bears little relationship to health plan enrollees' actual health status and health care needs. The GAO's methodology overlooks the reality that beneficiaries in FFS who have no supplemental coverage face substantial financial barriers to care due to Medicare's high cost-sharing requirements and, therefore, use substantially fewer medical services than their counterparts with supplemental coverage. The GAO's methodology erroneously would classify these individuals as healthier, when in fact, they likely could not afford to receive necessary care in the FFS program.

Question 4. I understand that many Medicare+Choice Plans have implemented disease management programs for congestive heart failure, diabetes, and other chronic conditions. How do enrollees benefit from these programs? Were you operating these types of programs in the Tampa area? If so, do those patients have access to the same quality of services since you have left?

Response 4. M+C enrollees benefit greatly from disease management programs offered by their plans. A study by CMS and the National Cancer Institute (NCI) found that Medicare HMO enrollees were less likely than fee-for-service patients to have their breast cancer diagnosed at late stages. Only 7.6 percent of Medicare HMO enrollees had a late-stage diagnosis compared to 10.8 percent of fee-for-service patients. (G.Riley, *Journal of the American Medical Association,* Vol. 281, Feb. 24, 1999) A large-scale study comparing quality of care for elderly heart attack patients covered by Medicare HMOs and Medicare fee-for-service coverage found that HMOs offer care equal to or better than fee-for-service coverage. All indicators of timeliness and quality of care for elderly patients with acute myocardial infarction were higher or similar under HMO coverage compared with fee-for-service coverage. HMO patients were more likely to receive betablocker therapy (73 percent vs. 62 percent). (S. Soumerai, *Archives of Internal Medicine,* Vol.159, 1999)

Another study found that Medicare HMO enrollees were more likely to have had a mammogram in the previous year compared to fee-for-service beneficiaries (62 percent vs. 39 percent). (L. Nelson, *Access to Care in Medicare Managed Care,* Nov. 1996) Research also has shown that Medicare HMO patients were diagnosed at considerably earlier stages, and therefore more treatable stages, than fee-for-service patients for four types of cancer: breast, cervix, melanoma, and colon. Among patients with cervical cancer, 76 percent of HMO enrollees were diagnosed at early stages compared to 55 percent of fee-for-service patients. (G. Riley, *American Journal of Public Health,* Oct. 1994)

Medicare+Choice plans are continually looking for new and better ways to improve the delivery of health care services. The following examples provide a glimpse of the many innovations Medicare+Choice plans are implementing on behalf of their beneficiaries:

AvMed Health Plan has designed disease management programs to improve care for beneficiaries with congestive heart failure, diabetes, end-stage renal disease and other chronic conditions. Group Health Cooperative offers exercise and fitness programs to improve beneficiaries' health and, additionally, provides a "road map" to physicians to assist them in delivering appropriate care to patients with chronic conditions. United Healthcare has established a "Care 24" program that gives beneficiaries access—24 hours a day, seven days a week—to registered nurses, counselors, attorneys, and a health information library.

Other plans have improved health care for their Medicare beneficiaries through innovations focused on: nutrition screening; the relationship between literacy and health; the impact of non-medical needs on medical outcomes; educational classes on osteoporosis treatment and prevention; overcoming cultural barriers; promoting clinical guidelines; and other opportunities for improving beneficiaries' health.

Another reason Medicare+Choice plans are popular among beneficiaries is that they typically offer additional benefits not covered by the Medicare fee-for-service program. According to a recent analysis by Mathematica Policy Research, 67 percent of Medicare+Choice enrollees are receiving some form of prescription drug coverage through their health plans in 2001. Other additional benefits currently available to Medicare+Choice enrollees include physical exams (99.7 percent), vision benefits (94 percent), hearing benefits (79 percent), podiatry benefits (30 percent), preventive dental benefits (27 percent), and chiropractic benefits (5 percent). Significantly, the lack of adequate funding for the Medicare+Choice program has forced many health plans to scale back additional benefits in recent years. For example, Mathematica reports that 84 percent of Medicare+Choice enrollees had prescription drug coverage in 1999—compared to 67 percent in 2001. The availability of most other additional benefits also has declined in recent years. I am enclosing a copy of *Innovations in Medicare+Choice Managed Care* for your information and hope that you will note the AvMed immunization program described at page 3 of the report.

RESPONSES FOR THE RECORD OF MARILYN MOON, URBAN INSTITUTE

Question 1. How well have private plans done at controlling cost increases over-time compared to Medicare? Is there any reason to believe that private plans are the solution to increasing Medicare costs? Aren't all payers/purchasers of health care facing the same problems?

Response 1. For several years in the mid 1990s, private insurers' premiums grew at a slower rate than Medicare per capita spending, but in the last five years Medicare has substantially outperformed the private sector in this regard. And viewed over an even longer period, Medicare has done better than the private sector in holding down the costs of care since 1970. All payers are having the same problems in coping with high health care spending. Improvements in technology and treatments are a prime cause of the growth in health care costs over time.

Question 2. Would moving Medicare to a system of competing private plans like that envisioned by Breaux-Frist necessarily mean that yearly cost increases would be lower than we see today in Medicare? Could the program find itself hostage to the private plans' premium increases with little ability to control costs without an act of Congress.

Response 2. I believe that a system of competing private plans would not hold down the costs of care. Savings to the federal government from such an approach would likely be achieved only if costs are shifted off onto beneficiaries in the form of higher premiums or cost sharing. Consolidation of plans has occurred quite rapidly in the U.S., often leading to only one or two insurers dominating the market in various locations. Such dominance would give them a great deal of leverage since it would be very disruptive to allow them to pull out of serving Medicare beneficiaries once they cover a majority of people in a particular area. In those circumstances they face few incentives to hold down costs.

Question 3. Stuart Butler mentioned in his testimony that the government should get out of the business of making decisions about benefits and setting prices and instead act as a referee for private plans. If the government doesn't develop provider payment mechanisms and fee-schedules, will the need to do this work go away? What would it mean for doctors and other providers to faced with a myriad of different payment systems developed by private plans?

Response 3. The complexity of the current health care system undoubtedly contributes to costs since in addition to the administrative expenses facing insurers, doctors, hospitals and other providers of care must deal with multiple rules and billing requirements. Costs are also high on beneficiaries to keep track of these issues. Changing Medicare to rely on private plans would likely increase these costs (unless

one insurer comes to monopolize the market, a circumstance that creates a number of key problems on its own). Moreover, if plans are allowed to compete on benefits and other key characteristics of coverage, this will likely increase adverse selection and lead to greater confusion among beneficiaries than currently exists.

Question 4. Medicare spends more than $240 billion per year on health care for 14% of the population. As a result of the aging of the baby boomers, Medicare spending and the Medicare population is only expected to grow. On the other hand, the Federal Employee Health Benefits Program (FEHBP) spends $21 billion a year for only 9 million people. Do you think that it is wise for Congress to step aside and let private plans make all the decisions about coverage, cost-sharing and other issues for the Medicare population?

Response 4. It would be very unwise for the federal government to take a hands-off approach to the provision of health care even if it relied more on private plans. Consumers often need help in dealing with insurers. FEHBP often uses its muscle to help its enrollees, and benefit officers in various agencies also intervene. Medicare beneficiaries would need even more support. Private aid from consumer groups and others would likely not be able to handle the volume of issues without strong government oversight.

Question 5. Mr. Butler also suggests there is an inherent conflict of interest in the way the Centers for Medicare and Medicaid services operates because it both oversees the M+C program and operates a fee-for-service (FFS) plan. Could you comment on this? Is there really a conflict?

Response 5. There is no necessary conflict of interest. Many private companies, for example, offer an indemnity program that they self-insure as well as contracting with HMOs to serve their employees. The goal of traditional Medicare (or a private company's self-insured plan) should not be to make a profit, but rather to serve the people it covers.

Question 6. Mr. DeMontmollin mentioned a number of times in the healing that Medicare fee-for-service and M+C should be forced to compete on equal footing. FFS should have to submit bids just like private plans and sink or swim. Could you comment on what this could mean for the availability of fee-for-service across the country? Could you comment on what this might mean for beneficiaries? Under such circumstances would fee-for-service be available and affordable for all beneficiaries all across the country?

Response 6. If we actually unleashed traditional Medicare to use its power in the marketplace, private plans could not compete with Medicare FFS. Moreover, it makes little sense to force Medicare FFS to reorganize like an insurance company. If it did, what would happen if the bid was too low? Would traditional Medicare pull out? Would it stop paying providers of care? Would it freeze enrollment of new beneficiaries? Would it have to create enormous reserves if 30 million or more beneficiaries choose to remain in Medicare FFS? Medicare FFS needs to be the default plan for beneficiaries and, as such, cannot be treated as just another plan. Thus, there should not be a presumption that traditional Medicare must compete with private plans.

Question 7. One of the problems with M+C is that plans get different payments across the country. Members of Congress and beneficiaries are upset because of the differences they see. If we move to a voucher system, does that solve the problem of geographic disparities in the cost of health care or would it leave the same problems in place or even potentially exacerbate the problems we see today? Do we have a good way to account for such geographic differences in the cost of health care today? How will these differences affect the premiums beneficiaries see in different areas of the country under a voucher model as well as the availability of fee-for-service versus private plans?

Response 7. The geographic differences are a problem whatever the organization of Medicare. A voucher system makes the differences even more visible, however. In addition, the theory behind having private plans manage care for beneficiaries was that this would lead to less variation across the country as a national norm of care would emerge. The fact that plans want to be paid according to the costs of fee for service in an area may be a tacit admission that they have not been very successful in actually managing care.

Question 8. On May 24th, 1089, the Congressional Research Service (CRS) issued a report to the House Committee on Post Office and Civil Service on the Federal Employees Health Benefits Program. In this report beginning on page 9, CRS wrote, "Choice in FEHBP has led to 'risk segmentation'... Plans have an incentive to limit benefits attractive to older participants, because they are required to raise premiums... Some plans have adopted aggressive marketing tactics that seem intended to appeal to younger people... Plans also have little incentive to incorporate cost control mechanisms if plan administrators perceive them to result in participant

dissatisfaction and migrate to another plan." Please comment on what this model, with its risk segmentation, avoiding older beneficiaries by limiting benefits that are attractive to them and selective marketing, and no incentives to control costs, would mean for the Medicare system.

Response 8. The most troubling aspect of a managed competition system is the possibility of permanently fragmenting the risk pool and leading to a separation of beneficiaries into the sick and the healthy. The easiest way for companies to hold down their costs is to attract a healthier than average mix of enrollees. If they do, they can offer good service and make a profit. But this is not a good system for those who are left out. Risk adjusters—which could help—remain more a wish than a reality. Moreover, since older persons have demonstrated that they do not like to make changes in their health plans each year, they may stay in an option that becomes inordinately expensive over time. We would be penalizing the sickest beneficiaries who are reluctant to make changes when they need care by allowing the market to work in this way.

Question 9. Proponents of a voucher model point to FEHBP as the ideal because they say it gives people a wide range of health plan choices. What can you tell me about what has happened to Plan choices in FEHBP over the past few years and how this compares to M+C? What does this say about the dependability and stability of a model based on competition and private plans?

Response 9. Health plans in FEHBP that offered generous benefits in one year have often had to pull back when they find they are attracting sicker patients. This occurred with mental health benefits in some of the plans, for example. Thus, the plans tend to offer very similar benefit packages with only small variations in cost sharing and other details. These details also can change from year to year in confusing ways. Similarly, Medicare+Choice plans have reduced the extra benefits they have traditionally offered. They have done so in part because of slower growth in Medicare payments, but more important is the fact that these plans cut benefits in ways to discourage enrollment by sicker beneficiaries. That is, they place caps on drug coverage rather than adding deductibles.

Question 10. Many of those who want fundamental reform of the Medicare program believe it is necessary because, over the next few decades, Medicare spending will consume an increasing percentage of gross domestic product (GDP). Isn't a significant portion of this increase due to the fact that the number of Medicare beneficiaries is projected to double from 40 million to 78 million in the coming years? How will the voucher model deal with the fact that the number of Medicare beneficiaries will double in the coming years? If Congress was to use vouchers to limit the government's spending in Medicare, wouldn't this just shift costs to beneficiaries?

Response 10. Much of the increase in projected costs will be due to serving both greater numbers of beneficiaries and a larger overall share of the population. We should expect the share of GDP devoted to this program to rise and begin to make plans for increasing the resources to do so. Another source of increase in costs will be higher health care spending driven by technological improvements. Do we want to freeze the quality and type of care that beneficiaries receive by establishing fixed limits on what the government will pay (i.e. through a voucher)? As a popular and important program, I believe it is crucial to continue to offer mainstream medical care to our most vulnerable citizens.